MENTAL HYGIENE

NO. 3

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VOL. XXIX JULY, 1945 NO. 3

THE MENTAL HYGIENE OF INDUSTRY AND RECONVERSION*

A THEORY OF MENTAL HYGIENE IN INDUSTRY

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FROM time unrecorded, in periods of emergency such as fire, flood, drought, or war, society has been able, by the exertion of collective pressure—whether through legislation or through what we call morale—to induce the individual to forego his personal interests in behalf of the goals considered essential to the preservation of the group. This collective pressure has induced the individual not only to give up his life and property, but also to improve his standards of performance, in the matter both of the quantity and of the quality of the goods and services needed for the attainment of the objective.

During this war, in addition to reliance upon morale, mental-hygiene programs have been instituted by the armed forces as well as by industry,[1] with the expectation that personnel management based on a more scientific evaluation of the psychological needs of the individual would lead to improved production and performance. These measures differ from those mentioned above, which stressed the socially valuable goal, by relating performance also to the mental health of the individual. The results reported are encouraging. Yet it seems too early—and the mental-hygiene set-ups

* Presented as part of the program of the Thirty-fifth Annual Meeting of the National Committee for Mental Hygiene, New York City, November 8, 1944.

[1] The term "industry," as used in this paper, refers to the totality of useful economic activities, including services as well as the production of goods.

in industry and in the army have been too limited—to warrant the drawing of definite conclusions as to the degree to which utilization of mental-hygiene concepts has contributed to increased production, over and above the contribution to be ascribed to morale. But one fact has been clearly established—that job adjustment is a major factor in the mental health of the adult individual.

Industrial Psychiatry.—These implications of job adjustment are pointing toward new orientations and concept formations in psychiatry. As pertinent data have been collected mostly in industrial plants, and only lately in the armed services and government departments, the term "industrial psychiatry" has been coined, to denote a new field of psychiatric theory and practice concerned with the so-called psychological aspects of a job.

Industrial psychiatry is concerned with all problems of "job adjustment," and has become increasingly aware of the implications that job adjustment has for the mental health of the adult person. Its field of observation and therapeutic advice extends to include adult individuals and adolescents of whom performance on the level of adulthood is expected. Its theoretical concepts must, therefore, be based on data relevant to adult behavior and performance patterns.

Mental Health and "Interaction Patterns."—Mental health has been defined as the ability of the individual to adjust himself to, and to cope with, the changing conditions that the various physiological, interpersonal, social, and economic fluctuations produce. It also is often referred to as integration.

In view of the various theories and hypotheses explaining the mechanism and dynamics of the process of integration, we consider it expedient at this point to elucidate the orientation upon which this presentation is based. Most psychological theories either emphasize the personal factors—that is, the biological, hereditary, or constitutional factors that the individual contributes—or stress the rôle that the environment plays—that is, the physical, social, cultural, and economic factors, as they influence the process of integration. The premise upon which our conclusions are based is that, though the above-mentioned factors must be taken into con-

sideration, the pattern shown by the interaction between the individual and his environment—that is, the means by which such interaction takes place—is of major significance. The emphasis of the present study is on these interaction patterns, as they relate to the process of integration, or the maintenance of mental health.

Mental Health and the "Social Act."—An adult and well-adjusted person develops a relationship to a group of individuals which he is not aware of as answering specific needs or selfish motivations, and yet the absence of which he experiences as frustration. This relationship, analyzed without any consideration of the emotional values attached to it, can always be disclosed as existing between individuals who have a common goal and who participate in some action to achieve it. This action we call, with the sociologist, George H. Mead, the social act.[1]

The value of the job, so far as mental health is concerned, is that the individual is able, with the talents at his disposal, to participate in the social act and, as a result of this participation, to develop a personality, logical thinking, reality functioning, and a code of ethics—*i.e.*, the individual also *becomes conscious of a moral end.* There is, therefore, a definite relationship between the individual's productivity, as implied in his job, and his becoming integrated or having mental health.

Mental Health and "Productivity."—In the "productivity" of the individual, however, we do not see an innate—*i.e.*, congenital—factor or quality, but rather a function resulting from the social development of a personality. Such development proceeds from an early or infantile level—on which the individual functions solely as a biological or physiological unit—to the level we refer to as mature or adult—on which the individual has developed a personality and a consciousness of self and has become a part of a larger group—that is, has developed social functioning.

During this process his interaction patterns vary with the development of his abilities and the recognition of the demands made upon him by his environment. It is only on

[1] See *Mind, Self, and Society,* by George H. Mead. Chicago: University of Chicago Press, 1934.

the level of adulthood, however, that he is able, as well as expected, to participate in the social process through his productivity. Thus productivity is the resultant of the various emotions, thoughts, and actions which comprise the individual's participation in the social act, and is concomitant with his social integration on an adult level.

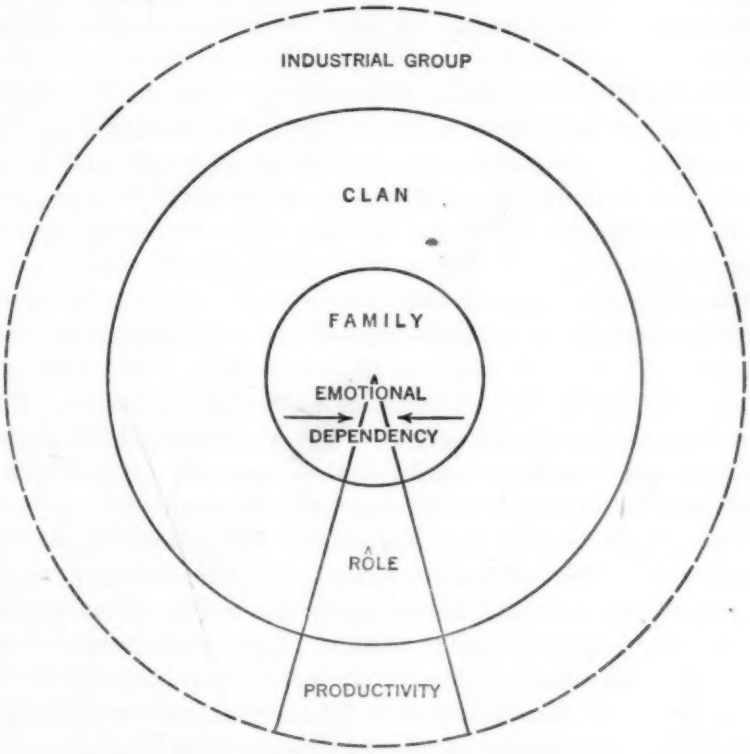
Factors in Integration.—Productivity does not, however, represent the only means by which the individual participates in the social process and attains integration. The factors that determine the means by which he attempts to achieve this goal will, aside from his personal abilities, education, and training, depend upon the requirements of the group of which he is a member and upon his adequate recognition of them. Failure to choose appropriate means for interaction is responsible not only for diminished work output, but also for personality disturbances which the psychiatrist is called upon to treat.

The factors, in the group of which the individual is a member, that determine the choice of adequate means for participation in the social act depend upon (1) the type of organization of such a group—as family, tribe, state, "United Nations," or the world; (2) the size of the group, whether it is small or large; (3) the goals or purposes of the formation of such a group; (4) the actual form taken by this coöperation between the individual and his group; and, finally, (5) the subjective experience of such participation.

We have analyzed the above factors in the group structures of the family, the clan, and what we suggest should be called the industrial or global group. These levels may be considered as focal points in the history of humanity so far as its social and cultural development is concerned, as graphically represented on the accompanying chart. This analysis suggests that the various manifestations of the psychological development of the individual, especially as they are related to the means by which he interacts with his group, resemble behavior patterns advocated for all individuals by social organizations at various historical levels.

This observation, however, does not imply that we are dealing here with an inevitable recapitulation of historical social dynamics in the life of the individual. It rather points

to the following fact, too often overlooked: the actual group of which the individual is a member and with which he interacts is not homogeneous in the development of its various fractions. The political structures of the societies we know, such as the state and the nation, contain concomitantly various group patterns, such as the family and the clan. It is



The circles represent three levels of group organization. The outer circle is drawn in broken lines, indicating that this type of organization is still in progress—*i.e.*, in the process of extension. The sector shows the means by which the individual attempts to integrate on the various levels.

the coexistence of these various group structures that determines the cultural pattern of our society, with all its complexities and contradictions, and creates the psychological atmosphere in which the individual functions. They also contain the factors that determine the individual's choice of means for his participation in the social act.

Therefore, though in a number of instances the individual rigidly persists in using means for the interaction with the group which are inadequate for the actual situation, the objective investigator may not always be able to allay his suspicion that in some instances the individual is either not encouraged or is even discouraged, in the use of adequate means for this interaction, by remnants of earlier group formations still present in our seemingly industrialized society.

The Level of Emotional Dependency.—The earliest group in which the individual participates is the family. Its size in comparison to other social groupings is small, and it has often been referred to as the basic social unit. The purpose of its functioning is, so far as the child is concerned, self-preservation, and, so far as the parents are concerned, a more extended form of self-preservation which sees in the next generation a continuation of its own existence. The actual form of such coaction is the feeding, protection, and rearing of the helpless, immature individual—functions that, simultaneously, apparently satisfy an essential biological need of the parents, usually called parental love, which a child fulfills through its dependency upon them.

The psychological manifestations characteristic of the social act in this group are intense emotional interpersonal relationships, which at times reach the degree of saturation of the participant's social needs. Any disturbance in the field of such an individual's interpersonal dependence is experienced by him as extreme frustration and anxiety, and may lead to symptoms of mental illness. It is the only social act in which the participation of the individual is experienced by him solely in the emotional cross-currents that exist between him and the other individuals that form his group.

This group might be expanded from the inclusion of near relatives to that of more distant ones if they live in the same vicinity; and further also to include neighbors who, under certain conditions, share in the same act—namely, the feeding and rearing of the child.

The Level of the Rôle.—Historically the enlargement of this group and its organization to contain all individuals that ascribe an ascendency to common ancestors is represented

in the tribe or the clan.[1] This group, much larger in size than the family, is organized for defense or aggression (accretion) and also for a more efficient method of production. The form of its social coaction is characterized by a rigid specialization of the individuals by their respective tasks, such as hunting, warring, and so forth, as well as by age and sex.

To a greater extent than in any other type of group organization, in the tribe or clan the individual's relationship to the other members of the group is regulated by a strictly defined set of rights and duties. The action pattern that corresponds to and is limited by these rights and duties has been termed by the social sciences "the rôle." The war chief, the medicine man, the mother demand of the individuals concerned very specific rôles which contain for them the meaning of the total value of their existence in this particular group and represent the only socially accredited forms in which they are permitted to participate in the social act.

The social validity of these rôles is often safeguarded and augmented by ascribing their genesis to ancestral and even to superhuman decree. The personal value of the individual is not perceived as a social emergent, but is, so to say, proclaimed by a code of laws and creeds. It is this aspect of religion that fortifies the individual's rôle and thus protects him against the additional demands as well as the restrictions that his group might otherwise impose upon him. One may, therefore, state that at a specific developmental stage of society—namely, on the level of the tribe or the clan—it is only religion that guarantees the value of the individual, enhances it, and fortifies it. This has often been referred to as the democratic principle in religion.

A similar extension of the original family group and its organization on a tribe or clan level takes place in the experience of the growing child. The members of this evolving group are not necessarily related by blood, but stress

[1] All group organizations that base their cohesion on the principle of belonging to the same race fall under the same type. An insurmountable conflict, however, arises if such an organization is ideologically superimposed upon a group whose extent and purpose of organization are beyond that of the clan or tribe. Even the temporary stability of such an organization can be maintained only by regimentation, strictly enforced by police power.

"belonging" rather than "striving" as the basic principle of their organization. Characteristic of this level is also a differentiation according to sex, stressed to a greater extent than in early childhood and late adolescence. This developmental phase is initiated with the child's first attempts at play and lasts until the individual reaches adulthood by becoming a productive member of his group.

At this stage, the rôle that one enacts is the measure of all value, and is the only means by which the individual becomes socially integrated. There is, evidently, a predilection in man, at a certain age level, to perceive the behavior of his environment and to exhibit his own reactions to it in forms that have been called "rôles." This phenomenon, observable either when the psychological development of the individual does not permit him to analyze the actual situation logically or when no other means for interaction are feasible, led Mead to call man "the rôle-taking animal." It is this human propensity that society has often utilized for organizational purposes, especially at the clan level.

The various manifestations of this psychological mechanism, which reach from *playing* soldier or policeman to *being* a good son, a Boy Scout, a member of a club, and *choosing one's vocation* on the basis of the "rôle" in which one wants to see oneself—that of a physician, a general, or a great actress—are beyond the scope of this paper. The implications of these experiences for the further development of the individual and his integration will be discussed later on.

The Level of Productivity.—Technological progress has, through the expansion of the lines of communication, transportation, and large-scale production with an extensive exchange of goods and services, transcended the borders of the largest groups we have heretofore known—that is, the state and the nation. Thus has been initiated an organization of individuals into a group that one might call a global community. This group is characterized by its size, its members being numbered in the billions. The motivations for the formation of this group, as of any group structure beyond the family level, are to be found in sustenance, security, and, finally, improved methods of production and distribution.

In addition, incorporated in the global organization is a

further goal which is the raising of the universal standard of living—made possible by the development of modern machinery and thus a direct result of large-scale production. Until recently this goal has manifested itself mainly in the international exchange of goods and services, but its materialization is advancing through such institutions as the League of Nations following the last war, and various present international agreements for defense and the maintenance of peace, and through the inception of organizations to regulate the relationships between nations, safeguarding their respective welfare and industrial development.

The enlargement of the group, however, is not necessarily due only to a numerical increase of its members. We also speak of an excessive enlargement of the social group when the individuals related to each other through the common social act are either so many in numbers that they cannot be personally known to each other, or so distant geographically from each other that their coexistence and coaction cannot be observed; or when the product resulting from the activity of each member participating in the social act forms so small a part of the completed product that the social value of each individual's performance is not easily recognized.

We thus must consider the concept of the *extension of the social group* as being conditioned by various factors. And it is in present-day industry, where large-scale production allows the individual so infinitesimal a participation in the completion of the final product, that the actual group in whose action he shares represents, from the individual's psychological point of view—*i.e.*, in his subjective experience—an extension of the group that might just as well be a global one.

It is self-evident that the individual can hardly participate in this global social act through an emotional evaluation of interpersonal relationships such as was adequate in the early group—*i.e.*, the family; nor can such participation be limited to a rôle pattern and the prestige to be gained from it among billions of other individuals. This enlargement of the group makes new demands upon the ability of man to achieve his integration and self-realization through participation in the social act.

To protect himself against a feeling of insignificance, he is tempted to resume feelings and attitudes that were adequate for earlier—that is, smaller—group organizations, and that would emphasize emotional relationships or the prestige inherent in a socially accredited rôle; and, as has been stressed above, there are often factors in his environment that might encourage such attempts. Or the individual may, through competent orientation and actual experience of productivity, become aware of his significance for this extended group and attain "freedom of choice" for the means of interaction with this group. Orientation courses given in the armed forces and the government departments, and the worker's representation and participation in labor-management committees, have rendered invaluable service in this regard.

No Rigid Demarcations.—Thus, in personal experience and subject to observation, the individual's participation in the social act normally develops from the emphasis on emotional relationships, into and over the formation of rôle patterns, to the participation in the social act through his productivity. It must be emphasized again, however, that, as the three types of social grouping mentioned above have no rigid demarcations either historically or in the biography of the individual, so far as the individual is concerned the means by which he participates in the social act and achieves integration also overlap.

Psychopathology—Disintegration.—We have interpreted signs and symptoms of disintegration, or mental illness, as resulting from inadequate attempts to participate in the actions of one's group. Such failures may be due to one or more of the following causes:

1. Faulty orientation. There may be a discrepancy between the actual size, goals, and organization of the group to which the individual belongs and his cognizance thereof. Physiological factors, such as congenital or acquired diseases, especially of the central nervous system, may result in this inadequate orientation, or insufficient information due to poor educational measures may be responsible for it.

2. Deficiency in aptitudes. Either of the foregoing condi-

tions may cause a deficiency in the aptitudes required for participation in the actions of the group.

3. Situational conflicts, which, however, we consider relevant only in so far as they interfere with a satisfactory performance level.

The disturbances that arise in such an individual have to be ascribed to his resuming attitudes, feelings, and thoughts that would have been adequate for a participation in the actions of an early group pattern, but that now fail to induce in him such plans and behavior as would enable him to participate in the social act of the group of which he is actually a member.

One psychological phenomenon which our observations have confirmed deserves special attention: Whether the individual's participation in the social act and his experience of it are mainly through the rôles he assumes or through his productivity, a disturbance in either is always evidenced by conflicts within interpersonal relationships. We consider this phenomenon important because it might mislead the investigator as to the true level of such an individual's attempts at integration, as well as to the etiology of the symptoms of which he complains.

The significance of this interpretation is all the more to be emphasized since modern psychiatry has shown, in the analysis of emotional illness, a tendency to stress the importance of interpersonal relationships for the etiology of psychopathological syndromes. Though we do not ascribe to this disturbance an etiological significance, we consider it as having diagnostic value and its presence has to be explained on the basis that integration is a social product and that every disruption of such integration, on whatever level it takes place, will be perceived by the individual as occurring within his social relationships.

This finding and its interpretation throw light on some complaints of employees who blame their failure to make an adjustment on disturbances in their interpersonal relationships on the job. The clinical significance of this factor will be brought out later on.

Job Values.—On the basis of the orientation that in productivity the individual finds the most adequate means for his

social integration in our industrial society, we have to attribute to the problem of job adjustment an importance that has not been stressed sufficiently in the past. *The problem of job adjustment is not solved solely by aptitude tests and job allocation,* but contains factors relevant for the mental health of the individual that demand our closer attention. The psychiatrist might state that the job has, aside from its dollars-and-cents value—that is, its *reality value*—certain other values of importance to the individual which apparently are satisfied in the well-adjusted person. Their frustration, however, may cause signs and symptoms of emotional conflict, lack of integration, and, often, failure on the job.

The problem of a maladjusted employee who has been referred to a mental-hygiene clinic in an industrial set-up should, therefore, be analyzed primarily with respect to the propensities of the job to satisfy his various psychological needs. These propensities of the job we have called the *job values;* their frustrations, as described by the individual, have proven of great diagnostic significance in ascertaining the actual cause of his disturbance.

These job values are not manifest on the surface and must, therefore, be revealed in a pertinent analysis. We have classified them as follows:

1. The *reality value,* which is represented in wages and salaries as they offer individuals economic security and a satisfactory standard of living.

2. The *social-saturation value*—that is, the value that the job has in helping the individual experience the saturation of his emotional needs for interpersonal relationship. Data indicating frustration of this value we interpret as related to the degree of disintegration, though, as explained above, they are unreliable for the analysis of the specific problem.

3. The *integration value,* contained in the opportunities offered to the individual in his job to express his specific abilities in productive work. Such opportunities will depend upon his training, his job allocation, the tools at his disposal, and the general work conditions, requiring at times testing procedures, but essentially representing a managerial rather than a psychiatric problem.

4. The *rôle value,* which we have defined as those propensities of the job which permit the individual the expression of a certain set of attitudes and a behavior pattern that have been determined by past experiences and by the cultural patterns of his group.

A mental-hygiene clinic is frequently called upon to deal with job-adjustment problems which we have related to conflicts arising out of the frustration of this last job value. The remainder of this study deals with our observations on this aspect of the job.

The Concept of the Rôle.—As we have indicated, the concept of the rôle as a behavioral unit has both a sociological and a psychological validity. Its psychological aspect was first studied in connection with social psychology. In its sociological reference, the rôle denotes an action pattern limited by a set of rights and duties. As a psychological concept, the rôle represents a framework for emotions, attitudes, and action patterns as they organize themselves in response to the stimuli in a specific situation. Here, too, the rôle is a strictly defined behavioral form limited by rights and duties that form parts of the present moral or cultural systems of the individual's group. These rights and duties may, however, in some instances be entirely fictitious, though they may possibly have prevailed in a situation long past.

On the basis of this orientation as well as our clinical observations, *we have defined the rôle* as that aspect of the behavior pattern which characterizes the performance of the individual prior to his objective analysis—and irrespective of the actual requirements—of the situation. This functioning form is determined by past personal experiences and by the cultural patterns of the society in which this individual is a member.

Of clinical significance, however, is the fact that the existence of these rôles in the individual seldom reaches the threshold of awareness. Yet our analysis of job situations and problems of adjustment thereto indicates that some opportunity has to be offered the individual to realize a minimum of his rôles. The disregard of this factor entails conflicts that interfere with the performance on the job.

There are various reasons why these rôle patterns, rather

than the advantages as well as the exigencies of the actual situation, so often influence the individual's behavior pattern and his choice of the means by which he attempts to achieve integration. For, historically, man has lived much longer at a level of group organization on which he participated in the social act mainly through the rôle, than he has lived in the industrial society in which the adequate means of integration is his productivity. His present group, though in the process of becoming an industrial society, still has elements of earlier group forms and, therefore, often encourages the utilization of rôle patterns, such as those that emphasize power and prestige, rather than integration by productivity.

Also, individually, our educational methods permit him only very late to participate in the social act other than through interpersonal relationships and rôle patterns. There is a tendency to prolong the educational phase rather than to reduce it, and it is as a result of this long period of education and training that the individual cannot, through an actual contribution of his productivity, grasp as yet a different means for attaining integration. Our educational institutions and various programs for the post-war period are taking this fact into consideration, and we feel, though the period of education ought not to be shortened, that during this period the adolescent should have opportunities to experience, through actual productive participation, the activities of our industrial society and its extent as a group. We define education as a response to the anticipated demands of a society, at the same time indicating the means by which integration can be achieved.

We have found, in a number of employees, a tendency to function only on a rôle level within a group organization that calls for a relinquishing of such rôle patterns in favor of greater emphasis on integration through productivity. At a certain level of development, as we have pointed out, the rôle has been a means of socially integrating the individual in a group beyond the intimate family circle, and thus has to be seen as a factor enhancing the growth of the individual. Where, however, in the adult the rôle pattern has become so rigid that it must be adhered to at the expense of his pro-

ductivity, it represents an arrestment on, or in some cases a regression to, an immature level of development.

Arrestment on the Rôle Level.—In some instances the rôle value of the job is found to be very high, and of such disproportion as to be the main incentive for the individual's performance. The slightest change in the job situation, however objectively insignificant, is experienced by him as a threat to his security and becomes a disturbing factor for the maintenance of his adjustment.

We have termed this phenomenon arrestment on the rôle level. It is characterized by a rigidity of pattern that does not allow a satisfactory adjustment to changing conditions as they occur in the industrial group, and it corresponds to what is usually termed a neurosis, especially if the individual is unaware of the rôle he is attempting to maintain. Such a person might have functioned quite satisfactorily in a group in which no demands that interfered with his rôle pattern were made upon him. As he enters a more advanced group formation, such as the industrial group, a conflict arises with his environment, engendering the feeling of failure, often labeled "inferiority complex." Anxiety and other "neurotic" symptoms develop as a result of his inability to reconcile the requirements of this larger group with his rôle pattern, and of his failure to choose the adequate means of integration.[1]

Psychotherapy is the traditional method of dealing with this rigidity of the rôle pattern. But we have recognized also the need for the employee to become better acquainted with the concepts mentioned above—namely, the size, organization, and goals of the group in the activities of which he participates and the adequate means of integration thereto. Such information has proved of great value when it could be related to the employee's actual job. It has constituted an adjuvant to the usual psychotherapeutic procedures and also has formed the basis for the preventive aspects of a mental-hygiene program.

Regression to the Rôle Level.—In addition to the problems

[1] The scope of this paper does not permit the citing of clinical material, which would extend from cases in which a relative awareness of the rôle exists, such as one implying a position of authority or leadership, to cases in which the individual is completely unaware of the rôle pattern, "the complex."

of job adjustment of employees in whom a rigid rôle pattern is diagnosed, we see employees in whom, on a superficial analysis, a rigidity of the rôle pattern also might be inferred, but in whom we are actually dealing with a regression to, rather than with an arrestment on, such a rôle level. In these instances, we are able to trace the employee's difficulties to his lack of opportunity or inability to interact with his group by adequate means and to become integrated through his productivity.

The symptoms resemble those of a neurosis. The differential diagnosis is, therefore, of utmost importance, for the therapeutic procedure in these cases lies only in the removal of the specific obstacles that obstruct the individual's productivity. Such obstacles might be the various physical disabilities found, for instance, in post-influenzal states and other convalescent conditions, as well as in mild chronic diseases of infectious and metabolic etiology, which need medical attention. Other cases included in this group, however, would be employees who were either "overplaced" or "underplaced," the latter often being those with high abilities, but insufficient training.

In other instances, the supervisor himself is the source of the employee's "situational neurosis." His own problems, whether they be rigidity of his rôle, lack of adequate orientation, or insufficient training for leadership, not only interfere with his own satisfactory performance, but create an atmosphere of instability and insecurity in which the employee will find it very hard to choose adult means for his adjustment.

The disturbance of integration in these cases is manifested not only in the attempt to establish a rigid rôle pattern, but also by a return to an earlier level on which the attractions and repulsions of interpersonal relationships are the only means by which the individual can orient himself in the group of which he is a member. The therapeutic procedures will consist in testing the employee's abilities and elucidating the problem of his job allocation; the alleviation of the factors responsible for his failure in the actual job situation are the task of personnel administration.

Differential Criterion.—The symptoms in these *two types of faulty job adjustment* that we ascribed to arrestment on,

and regression to, the rôle level may, as we have pointed out, be very similar. The criterion that differentiates them is to be found in the pattern of the individual's interpersonal relationships. The person *arrested* on the level of the rôle is observed to have limited his interpersonal relationships to those individuals among whom he can maintain his particular rôle, and to have eliminated from his field of perception all those who might jeopardize its maintenance. If reality does not offer him the possibility of associating with individuals who help maintain this rôle, he withdraws to a phantasy level and his daydreams interfere with his productivity. The one person with whom he usually has conflicts is the supervisor or foreman. While the other employees are subject to his very selective scrutiny, the supervisor, forcing him to the level of reality by demanding production of him, constitutes the greatest threat to the security and equilibrium of his rôle pattern.

In the employee who has *regressed* to the rôle level for the reasons mentioned before, we find, in addition to the emphasis on the rôle, his interpersonal relationships full of conflicts involving all members of the group to which he belongs—*i.e.*, not only the supervisor, but also his fellow employees. Often, however, there is total lack of awareness of his social difficulties, though co-workers as well as the supervisor complain of his disturbing behavior and attitudes.

Mental Hygiene in Industry.—Requests for a differentiation between the behavior patterns described above are the most frequent reason for the referring of employees to the mental-hygiene clinic. Their etiology and requirements for adequate management define the tenor of our recommendations to personnel administration.

This approach points the way to psychotherapeutic measures more expedient than those based on a science of man which disregards his job and the values inherent therein, the satisfaction of which represents an essential condition for the maintenance of the mental health of the adult in our industrial society.

It also reveals the importance and responsibility of personnel management and stresses the need for increased cognizance of all those factors mentioned above, with pertinence for the mental health of our productive population.

This orientation is founded on increasing knowledge of the expanding domain of personnel management as well as of mental hygiene; it goes beyond interest in the individual to include society.

In the final analysis, such orientation is based on faith in the premises of a democratic social order. For democracy is the process by which each individual is offered an opportunity to participate in the act of the group to which he belongs, commensurate with his abilities and talents.

SUMMARY

1. The mental health—integration—of an individual is a result of his participation in the social act by means adequate to the extent of the group and its organization.

2. On the various levels of group organization—family, tribe, industrial group—the means by which an individual participates in the social act and becomes integrated are: (a) emotional dependency, (b) the rôle, (c) productivity.

3. In our present-day society all these three levels of organization exist concomitantly. However, its main characteristic is its industrial organization, so that it virtually represents a global group and requires productivity as the appropriate means for participation in its social act. As this productivity is related to the job, job adjustment implies mental health.

4. A method of job analysis is proposed, based on the propensities of the job to satisfy the psychological needs of the individual, classified as: (a) the reality value, (b) the social-saturation value, (c) the integration value, (d) the rôle value.

5. The task of mental hygiene in industry is seen to be: a more accurate differentiation between "psychoneurosis" and similar behavior patterns caused by lack of opportunity to utilize one's abilities in productive endeavors; the contribution of a scientific analysis of the various problems that result from faulty job adjustment; and the development of measures for their solution.

6. This orientation becomes a prerequisite for scientific personnel management as well as more adequate psychotherapeutic measures.

CONCLUSIONS

Psychiatry approaches its rightful place among the social sciences. The knowledge it has accumulated is ready to be used for the advancement of the health of the population. Mental hygiene aids the individual in his attempt to integrate and to realize himself as a member of the group—the largest group that ever existed, the industrial group. As for the social implications of this orientation, the pronouncements of leaders of government, industry, and labor indicate an increasing understanding that employment—*i.e.,* the job—is the pivot of a healthy social structure.

Parallel to the ascendancy of mental hygiene as a social science, personnel administration emerges with a key rôle in the social process, privileged to make great contributions to the health of the total population.

In this development we see the progress of democracy, enabling an ever greater number of indivivduals to participate in the social act of the industrial group and, through such participation, to achieve integration, self-realization, and mental health.

THE DYNAMICS OF MENTAL HYGIENE IN INDUSTRY

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INDUSTRIAL psychiatry is a fledgling clumsily trying its wings. William Alanson White predicted a brilliant future for this proposed discipline in his *Twentieth Century Psychiatry.* Yet Elton Mayo, in his *Human Factors in an Industrial Civilization,* a book based mainly upon the important experiments at the Hawthorne Works of the Western Electric Company, repudiated the necessity for psychiatrists in industry, despite the fact that he leaned heavily upon psychiatric formulations and used a psychiatric approach. He feels that the human problems encountered in the plant are not "mental disorders," and that they can be dealt with adequately by foremen, personnel worker, and employment interviewer.

This characterization of the psychiatrist as only a "nut doctor" prevails in many quarters, although the stress of recent events has caused industry to turn more and more to psychiatry for aid in the solution of some of its problems. Industry can profit from psychiatric knowledge and experience, but psychiatry, before it can teach, must be aware of the problems and aims of industry.

The present war, with its all-out effort, has brought the problem of psychiatric disorders to the fore. One and a half million veterans have already been discharged from the armed forces, 30 per cent of them, according to military statistics, for neuropsychiatric conditions. This vast number has brought dismay and fear to those obliged to employ them. Many employers have apparently confused the term "psychoneurotic" with "psychotic," and seem to anticipate that a veteran with a psychoneurotic condition, if let loose in a plant, will throw a monkey wrench into the first available machine. The armed forces have attempted to allay this apprehension by omitting the diagnosis from the discharge certificate. As far as I can see, this aggravates matters, since things concealed assume an even more dreadful aspect. Industry has always been faced with the problem of the maladjusted individual, but he was not labeled with a fancy diagnosis and so no one was afraid of him.

Selective Service figures give us some indication of the prevalence of emotional disorders in the community. Of the first 10,000,000 registrants screened, 2,800,000 were classified 4-F. Of these, almost 900,000, or roughly one-third, were so classified for various neuropsychiatric and psychosomatic conditions. The group examined, aged eighteen to thirty-eight, is presumably in the prime of health. Should this rate apply to the rest of the population, then at least 11,000,000 persons have a neuropsychiatric condition sufficiently severe to be manifest in a single short examination. If you have read Stanley Cobb's excellent monograph, *Borderlands of Psychiatry,* you will find these figures confirmed from another approach.

These figures are enormous and indicate a problem about which shockingly little is being done. Those of us, however, who have had the pleasure of participating in Army Induc-

tion Board examinations can testify not only to the large numbers so affected, but more surprisingly to the large numbers of psychiatrically handicapped individuals who are managing to adjust themselves to everyday life, working and discharging their obligations as useful citizens, although at a cost to their personal comfort.

There is no question as to whether or not industry can utilize psychiatrically handicapped individuals. Industry has been doing it, often without realizing it, and perhaps not as efficiently as it might. Attention has been drawn to the fact that certain undesirable industrial traits, such as absenteeism, frequent job changes, poor work habits, prolonged invalidism, and accident-proneness, may in large measure be due to emotional factors. Yet, if industry were at this moment to discharge every one with a psychiatric disorder, not only would all the psychiatrists in private practice in this assembly have to go on relief, but industry would find itself seriously handicapped. Every psychiatrist here can testify that some of their sick people are doing fine jobs in labor, industry, the arts, and sciences.

We should remember, however, that the responsibility for the treatment of these disorders is up to the individual and the community. Industry, even in Russia, is run for profit. Industry can never be run for the sole purpose of occupational therapy. The major problems that psychiatry has to aid industry solve are: (1) to devise means of separating the wheat from the chaff, the large numbers of employables from the small numbers of unemployables; and (2) to improve methods of job placement and handling of the emotionally handicapped.

Theoretically, I suppose, it would be a fine thing if every plant in this country could utilize the services of a psychiatrist. From the practical point of view, it is impossible and perhaps unnecessary. There are only about three thousand members of the American Psychiatric Association, so that there are not enough psychiatrists to go around. Further, 65 per cent of the people working in this country work in plants employing fewer than five hundred persons. Such a plant cannot afford a full-time medical man, much less a psychiatrist. Those who would propose the use of complicated

screening tests for prospective employees must bear in mind that in smaller organizations specialists will not be available for the administration or the interpretation of such tests. Even in larger plants it is hardly to be expected that psychiatrists will be be used instead of placement officers or supervisors. The psychiatrist will be of greatest use by acting in an advisory and consulting capacity to the medical staff, the personnel department, and indirectly to the supervisory personnel.

A word about the responsibilities of a psychiatrist in industry. It is that of any industrial physician, except that it is along the special lines for which his training has equipped him. The industrial physician has three main functions: (1) to assist in the placement of applicants for employment; (2) to treat any medical emergency that occurs among the employees while at work, and any condition that arises out of working conditions; and (3) to initiate any program that will prevent or diminish mental and physical illness among the workers.

In brief, as in the army, he is responsible for keeping as many people at work as possible.

The Psychiatrist and Placement.—There are important differences between the mental and physical requirements of the armed forces and of industry. The armed forces obligate themselves to treat almost any condition that arises while the man is in uniform. This may entail prolonged hospitalization, the utilization of expensive equipment and skilled man power, often evacuation over distances that may cover half the globe, and pensions for permanent disabilities. Also, the fighting man must be capable of withstanding tremendous physical and mental strains, including the threat of death. Industry makes no such demands, and assumes none of these obligations. It is quite obvious, then, that entirely different criteria for employability are needed in industry.

When labor is plentiful, the industrial physician can ease things for himself and his company by a rigid system of selection of employees. During the present emergency, however, with the shortage of man power, his ability to select is sharply curtailed, and he must utilize the residue left by the armed forces. One can only hope that the end of the war

will find the labor market still "tight," because while a labor oversupply may make personnel selection easier, it does so at the cost of tremendous economic waste, the burden of which must be borne by the community and indirectly by industry.

Before the psychiatrist can offer advice as to the employability of an individual, he should understand something of industrial-placement procedure. Often enough, when a worker with a neuropsychiatric defect is referred to the specialist, a lengthy report is returned which includes a well-thought-out diagnosis. But the poor plant manager hasn't the vaguest idea what to do with it, because the essential questions as to whether, where, or how the man can be employed are not answered.

In a small plant the question of placement, of matching the applicant to the job, is simple. The proprietor knows every job in the plant, and a little about the personalities involved. It is relatively easy for him to know in advance that John Doe will fit in and can do the job in question. When plants become larger, types of jobs more numerous, and the question of interpersonal relationships more complex, then the employment interviewer finds himself almost in the position of placing a man he has just met into a job he does not know, to get along with personalities he knows only by a serial number. To counteract this, comparatively complicated placement procedures have evolved that are making personnel work a profession. But the problem still resolves itself into sizing up the job, sizing up the applicant, and matching them.

Each job has certain requirements, or demands. These are:

1. *The physical demands of the job and its environment.* The United States Employment Service of the War Manpower Commission has worked out a careful job-analysis scheme. As jobs become more specialized, fewer physical requirements are demanded. These requirements are specifically stated, both for the job itself and for the working conditions. From twenty to thirty different items are included under physical activities (such as walking, balancing, sitting, handling, fingering, seeing, hearing, depth perception, and

so forth) and a similar number under working conditions (as inside or outside, hot, cold, dry, noisy, dusty, hazardous, working with others, and so forth). A surprising number of jobs will be found that will require but one arm, no vision, or no hearing, and so on.

2. *The intellectual demands of the job.*—This requires only a rough approximation which can be determined by finding out roughly the intellectual level of those best performing a certain job. It is as much a mistake to place too bright an individual as too dull a one on a job. The bright one becomes bored, careless, and indifferent. The excessively dull may seek any of the compromises and escapes known to psychiatry to preserve his ego rather than acknowledge his inferiority.

We had one veteran, a parachutist discharged for a back injury, whose mental age was 9. We recognized this and thought we had a relatively simple job for him in the packing department. Within a few days we were told that his conduct was bizarre. Upon investigation, we discovered that what we had considered a simple job involved packing twenty-five different items in fifteen different packages as well as the operation of a stitching machine. It was far beyond his capability, and the escape he chose was a psychotic one. Our error was based upon a faulty evaluation of the intellectual demands of that job.

3. *The technical demands of a job.* The best judge of this is the supervisor, who can also determine whether the applicant has the necessary experience and skill. This applies especially to the more highly skilled jobs. I would no more attempt to decide whether or not a man is a good tool-and-die worker than I would expect a hospital stewart to choose a clinical director or a pathologist.

4. *Intangible factors.* These include the emotional demands of a job. We confess our inability to determine all of these factors. We know of no way of doing a Rorschach on a job. We are doing the best we can. If we knew all the answers, we would know why some people make good policemen and others good barbers. We would not hesitate to employ an effeminate individual as an illustrator or in certain types of clerical positions. We would refrain from putting him into the foundry. We have found that we cannot place persons

with perfectionistic tendencies in certain departments in our concern, but we are not certain of the reason. An interesting illustration is the experience of the British Army. One would suppose that the person best suited to drive a tank would be one with previous mechanical and driving experience. Yet cab drivers did poorly in tanks. Apparently the taxi drivers were accustomed, all of their lives, to stay in line and avoid collision. The tank requires a crashing, destructive tendency which has been trained out of cab drivers. It is these intangible factors that make an ideally complete job analysis difficult.

The job analyst is responsible for compiling these job requirements for each job, and the results are compiled in a manual accessible in the employment office. What has been done with the job must now be done with the prospective employee. This is done by the employment interviewer with the aid of the medical department and various specialists, including a neuropsychiatrist. The individual is studied to discover what his capacities are, and the outline follows that of the job requirements. These are:

1. *Physical assets.* The interviewer is furnished with a comprehensive medical diagnosis from which he determines what the applicant's physical assets are. The interviewer's attitude is a positive one. If a man is deaf, he can still walk, finger, employ a known amount of depth perception, and so on. As a matter of fact, he is at an advantage in a noisy environment. Using this type of approach and attitude, the placement of the physically handicapped is a comparatively simple proposition. Where difficulties are encountered, one can presume that emotional complications are interfering.

2. *Intellectual assets.* In this part of the country, where schooling is universal, the applicant's rate of progress in school is usually a sufficiently satisfactory index of his intelligence. Where required, brief psychometric examinations may be performed. We believe that too great an attempt at accuracy in this regard with all employees is unnecessary and involves an excessive expense.

3. *Technical skills and experience.* These are brought to the attention of the prospective supervisor, who is the final judge.

4. *Emotional assets.* We use this term deliberately because we have found to our dismay that psychiatric diagnoses by themselves are not the sole criteria in placement. Ordinarily one would presume that the psychotic is universally unemployable. This is not entirely true. Two illustrations will be instructive.

I have in private practice a former pugilist who is punch drunk (post-traumatic Parkinsonism). For the past fifteen years he has been suffering from a paranoid condition. At the beginning, he discovered, to his dismay, that he was impotent with his girl friend. He watched her carefully, but could never catch her putting into his beverages the drug that he was sure was causing the condition. At times, when he turned suddenly, he could see rivals lurking in the shadows. In self-defense, he broke off with her. Since then people have been trailing him in the subways and emit foul odors to disturb him. His only explanation is that he must have slighted some one in the past, and so this man and his family have tormented him since. During this entire period of at least fifteen years, he has been working steadily. In the past four years he has been employed in a war plant cutting steel. I understand that his work is satisfactory.

One more illustration. While being visited at Sperry by the psychiatric consultant of the Office of Vocational Rehabilitation, I examined a veteran. Although neatly dressed, his speech and thought were so disorganized, and his affect so flattened, that I asked him if he would return with a member of his family. His father was in the waiting room with him. We learned that he had been discharged from a state hospital five years before. A little over three years ago, he enlisted in the marines, and served two and a half months. just long enough to be recognized as a deteriorated præcox and discharged. Since then he had been steadily employed elsewhere as a machinist, earning $90 a week. He had never missed any time from work, had saved his money, and had never been in any difficulty. We confirmed this story and employed him as a machinist, and so far he is doing well, although his colleagues consider him queer.

On the other hand, we had a former Sperry employee who served eleven days in the navy. Prior to his induction, his

supervisors were having increasing difficulty with him. Because of his seniority, and because he was due to be drafted, he was tolerated in order to protect his military-leave bonus. Upon his return, however, he objected to the routine reëxamination procedure, and in particular to the vision test. He was brought to another plant to have the vision test repeated. The oculist felt that he was having difficulty in passing the test for emotional reasons. His attitude was so bizarre in the employment office that he was asked to see me. He was mildly paranoid, but his trends were directed against the company and the supervisors. Because of his veteran's status, and our legal and moral obligation, he was reinstated into his former position, with the understanding that he was to see me regularly. He soon developed trends against his machine. His work fell off, and the problem of supervision became insolvable. I prevailed upon him, I thought, to take a medical leave of absence in order to enter an institution for treatment. Apparently he changed his mind and notified the Selective Service System that we had given him a medical leave rather than a release only to prevent him from working elsewhere. We had to dismiss him.

I chose these three cases deliberately, not so much to demonstrate that schizophrenics are occasionally employable—as indeed they rarely are—but to show that a psychiatric diagnosis by itself is of little use in industry. These three men suffered from like conditions; two of them, one deteriorated, are employable; the third, and probably the least sick, proved unmanageable. This holds true for every psychiatric classification, although with the psychoneurotics, the percentage of unemployables is smaller.

So we have instructed our employment interviewers that they can almost disregard any history of a nervous breakdown. We have told them that, as a matter of fact, certain types of psychiatric liabilities, such as obsessiveness, perfectionistic traits, and so on, if properly channelized, may constitute industrial assets. We object to an exclusively cross-sectional view of an applicant and demand that he be viewed from the longitudinal point of view. Consequently we feel that the employment interview, properly conducted,

constitutes the best guide as to placement, although we are experimenting with group Rorschachs, and so on.

The employment interviewer is instructed to adopt the neutral attitude and to permit the applicant to tell his own story as much as possible. In evaluation, emphasis is placed upon his previous work history, and his previous school history. If he is a veteran, his army record is examined for evidence of leadership shown, and special skills learned. We are interested in the attitudes he has shown to persons in authority. We are interested in evidence of maturity and responsibility as shown by his marital status, his savings, and his attempt to establish a home. What his attitudes are to himself and to any defect present are also noted. If he is a veteran, the length of time it has taken him to apply for a job is significant. Generally speaking, the sooner a veteran wants to begin work, the better his prospects. The veteran who has to rest at home, for vague reasons, is often a psychoneurotic who lacks insight and is fleeing from his problems. On the other hand, the veteran who states that his nerves were shot and so he did not want to work, but that now he feels better, at least has some insight and is making an attempt to face his difficulties. Should there be any question, the employment interviewer is free to request a psychiatric consultation. This serves a double purpose. First, specific advice is given on the problem. Second, the discussion that follows the consultation points out the factors involved and aids the interviewer in his orientation.

All the above must seem like a cumbersome process, but actually it works out quite smoothly. When a former employee applies for reinstatement after discharge from the armed forces, the problem is much simpler. We know what he has done in the past. Also, the applicant knows what the job was, and the mere fact that he is reapplying shows that he was happy with the former placement. When the former job is no longer present, or when the physical or mental status of the applicant has so changed that he is not the same person as he was previously, it is necessary to make a new placement.

The applicant who is referred to me for evaluation is told that he is being referred to a psychiatrist in order to achieve

a more suitable placement. The suggestion made by some that the industrial psychiatrist ought to mask his identity under some other description, such as plant physician, and so forth, smells to me like chicanery and intellectual dishonesty, the result of personal feelings of inadequacy. I have found no resentment in any one referred to me. On the contrary, a few veterans have complained that they have not been "psyched" and do not want to be left out. The employee is under no compulsion, and what he reveals is considered confidential except for the brief report sent. Not a few have requested further interviews.

So far as employment prognosis is concerned, I rely chiefly upon an evaluation of the *previous work record.* Where a neuropsychiatric condition is present, consideration is given to acuteness of onset, severity of precipitating factors, previous personality, duration of illness, adequacy of treatment, presence of affective features, whether or not improvement is continuing, presence of some degree of insight, and what the motivations are that determined the man's return to work. The presence of antisocial trends generally precludes employment. Accident-proneness is considered a bar to employment. Psychopaths may be employed if they can be without expenditure of money for training. Epileptics may be employed in certain sheltered situations, if they have an aura, are under treatment, and are capable of handling themselves in case of a fit.

In a few instances veterans have returned prematurely, but examination indicated that they were improving and would be ready for work at a later date. These veterans were so informed. Some of these were given stop-gap jobs until they were ready to return to their former jobs.

After placement, a follow-up is maintained by the employment interviewer, the supervisor, and, in the case of veterans, by a veterans' counselor. If for any reason the placement appears poor, reassignment or other adjustments are made. This attitude that mistakes will be made enables all concerned to learn from mistakes.

The Psychiatrist and Supervision.—The crux of any rehabilitation program, after placement, is the supervisory personnel. The supervisor sets the morale of the department,

and can make or break any rehabilitation program. Apprehensions arising from misconceptions of the psychoneurotic concern him. He must get out production and fears any one labeled as a "nut." To allay these fears, we have been addressing foremen on the subject of psychoneuroses, mainly for the purpose of reassurance. In addition, educational slide films are being prepared. Technical terms are avoided. We assure them that the problems they will face with the returning veteran are no different from those they handled previously. They are given simple and sensible instructions. Where a problem gets beyond them, the personnel department is available for help, as is the veterans' counselor, the medical department, and the psychiatrist.

In the lectures, anxiety is explained. They are told that in most instances the conflict is resolved by discharge from the service. They are warned that curious questioning and unskilled probing may rub the wrong way. Griping is explained as being due to a combination of two variables—the manifest content and the latent. The manifest content must be investigated. The latent content is due to emotional factors not necessarily connected with work and is often benefited merely by permitting the employee to blow off steam. They are told that psychotic states are rare. They are warned of the guilt feelings that follow discharge and of the necessity of rebuilding a new group spirit quickly. The emotional adjustments and reorientation that must be made by the veteran when he returns to his home and to work are explained. Supervisors are enjoined to be patient. They are told that it takes a year of military training to make a soldier out of a civilian, and that it will take a period of "peace-time training" to readjust him to civilian life. The placement program is fully explained. These lectures have found an enthusiastic reception.

Psychotherapy in Industry.—The lectures and consulting service have resulted in a valuable educational program that has benefited the medical department, the personnel department, and the supervisory personnel, affording them a valuable insight that has enabled them to recognize emotional problems at the beginning. The simpler problems thus have been resolved more readily. No formal psychotherapy has

been attempted, although of course one cannot conduct a psychiatric interview without giving some aid and comfort. Where psychotherapy was deemed advisable, the patient was referred to a private physician or an outside agency. We hope that the facilities available for psychotherapy in the community will be expanded after the war. So far as veterans are concerned, there are a few clinics doing a commendable job, but they are swamped by appeals for help. I hope that the Veterans Administration will be able to offer out-patient psychiatric care. The firm that I represent has arrangements with a private sanitarium by means of which we can handle those of our employees who require a short period of institutionalization under our group-hospitalization plan.

The ability of an employee to let off steam by griping and an understanding on the part of the supervisors of the nature of griping provide a helpful release of emotional tension, and often uncover employment situations that require correction. The filing of grievances is a more formal step in the same direction. The suggestion system offers an opportunity to make positive contributions to the company, and the labor-management committees give both parties an opportunity to understand seemingly contradictory points of view, which around the conference table do not turn out to be quite so contradictory.

Psychiatric Emergencies. — The psychiatric conditions encountered among employees are as varied as those seen in private practice. One girl was hospitalized during a minor infantile-paralysis epidemic, complaining of inability to open her left hand. Sodium pentothal narco-analysis uncovered an emotionally starved family background, with the present situation precipitated by rejection by her love object, coupled with marked feelings of guilt over what the hand had held, which she was unconsciously unwilling to release.

A less favorable outcome was achieved in another situation. A fifty-four-year-old white male had taken to drink after the death of his wife, apparently in a blind attempt to repress incestuous desires toward his daughter. When I saw him, he was in a state of pathological intoxication coupled with a paranoid trend. He was committed. Within a week,

however, after the effects of alcohol had worn off, he was able to talk himself out of the institution. When I saw him again, his sensorium was clear, but he presented a well-systematized delusional system involving his daughter's morals, so cleverly constructed that his friends were convinced. Despite warnings to the daughter, she made no further attempt to commit him. Of course we would not permit him back at work. A few weeks later he made a murderous attempt to stab his daughter.

CONCLUSION

The exigencies of war are bringing industrial psychiatric problems to our attention. Mental hygiene in industry must utilize as much as possible facilities already present in industry. Psychiatrists can contribute much to proper placement and better labor-management relationship by an educational program, and by acting in a consultant capacity. This program should attempt to improve the employment interview, methods of placement, and supervision. Aside from the financial savings inherent in such a program, which we feel are considerable, the saving in human values is inestimable. Enlightened management, which looks upon good labor-management relationship as important not only to the community, but, financially, to the company as well, will be quick to inaugurate such programs.

THE IMPACT OF FAMILY FORCES ON THE SOLDIER AS MET BY THE MILITARY SOCIAL WORKER

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AS the family has exerted its influence upon the individual throughout his development, so its impact continues to be felt after army induction. The object of this paper is to discuss the effect of such influences on the soldier, and to consider briefly what the military social worker can do to assist him in making the necessary adjustment without creating more disharmony in a family already beset with the problems connected with separation.

The problem takes on added importance as we begin to think of demobilization and rehabilitation. The gaps and maladjustments in family life, brought so sharply into focus by separation and military service, will have to be closed and healed if adequate readjustment is to be made by the returning soldier. That will be the responsibility of civilian social work. In the fullfilment of that responsibility, it will be important to know both how the soldier has been affected by these family forces during his period of service, and how the military has tried to help him make the transitions.

In various capacities, social workers are used within the army to cope with individual problems of adjustment. The specific settings within which they function vary with the local military needs. They work as members of consultation services, in rehabilitation centers, reconditioning facilities, and similar installations. Wherever they are assigned, they bring an understanding of, and a skill in, helping individuals within social situations.

While the essential skills of military social work are the same as those of all social work, the conditions under which they are practiced are different from those in any other

* Presented at the Colorado State Conference of Social Work, Denver, October 6, 1944.

setting. The military social worker functions as a representative of authority in a strongly authoritarian setting. His help must be limited to extremely brief contacts. Yet brevity does not imply superficiality or a lessening of standards. The demands upon him for concrete results are as great as anywhere in civilian life. Lives and victory are at stake in military social work. He works likewise under a "sword of Damocles" situation, never knowing when either he or his client will be moved to a new post where the military need is greater. Since he comes into a case-work relationship with the same background as the client, and since the conditions during the relationship are the same as those met in the living of the client, much can be accomplished in very brief spans of time where the social worker has learned to use the structural tools thus provided and understands clearly his functional relationship to military authority.

As we consider the influence of the family upon the soldier, we must avoid thinking of it as necessarily detrimental to military adjustment. On the contrary, it provides, in most cases, a positive influence that can be used constructively by the soldier in making the transition into army life. Secure in his rôle within the family, confident of their acceptance of him, and aware of their concern for him, he can retain a sense of self-sufficiency and status, and avoid that sense of being lost which characterizes so much of military maladjustment. He can use the family as a fixed point from which he can take his orientation in the uncertainty and confusion accompanying his attempt to meet the exigencies of army living.

Through correspondence and direct contact, the family provides a source of expression for much of the aggression, resentment, and other feelings that he cannot bring out directly within the army. It gives support to his strivings. More important than all, it provides a goal that remains warm and alive and that sustains him through his worst experiences —the goal of return to his family and resumption of family living at the end of the war.

Where the respective rôles within the family have not been firmly established, and where the individual has failed to develop a sense of adequacy within the family constellation, separation creates many conflicts that are reflected in his

army functioning. The family, unable to provide the necessary support and lacking the strength adequately to meet the problem of separation, in turn exerts pressures that add still further to the soldier's difficulty in adjustment.

The army and its authority are used by the soldier in terms of his individual needs and conflicts. No one rôle can, therefore, be assigned to the army in considering its relation to family dynamics. Some men react to the army as a symbolization and embodiment of parental authority. A soldier who had carried on a constant conflict with his father over authority, and who had completely rejected that authority, upon induction into the army continued his conflict and projected upon the army all of his feeling about parental authority. He was unmanageable and useless until this projection could be broken down.

Another soldier may use the army to shelter and protect himself from family responsibility, and to provide the confidence and acceptance that he failed to find within his familial rôle. Still another soldier, through the use of military authority and complete identification with that authority, may find in the army the responsibility that family forces prevented him from assuming. The army and its members then become things to be protected and defended.

Thus we see the army and its authority being used psychologically in any number of different rôles, depending upon the individual needs of the soldier. The military social worker who works with the resulting problems must be constantly aware of these psychological meanings of the army to individual soldiers.

Many of the men who come before the military social worker are those in whom separation from the family has intensified their doubts concerning their adequacy within the family. A soldier came whose extreme concern for his family was preventing his doing efficient work. From his description of the family situation, the entire family seemed to be disintegrated because of his absence. He was helped to overcome his reluctance to use the American Red Cross to determine whether any specific help could be provided. The Red Cross worker, who visited the family, reported that the wife felt the family was getting along better in the soldier's absence than it had ever done while he was there. It was the insecurity

that he felt within himself which caused him to feel that his family was so dependent upon him that it could not manage independently. A subsequent interview revealed the soldier to be so inadequate personally that a satisfactory military adjustment could not be expected of him.

For some soldiers, the news that the family is managing without them creates considerable disturbance. Doubting their own adequacy as they do, to them this is evidence that they have no real place within the family. Where alertness and complete effort are necessary, such feelings may seriously interfere with military functioning. In such cases the social worker must try to help the soldier develop a greater degree of adequacy within the army, which can sustain him and, through his increasing competence, enable him to feel that upon his return to civilian life he can resume his rôle as family head.

Until now we have considered largely the problems that have their genesis within the soldier himself. There is another large group of problems where, were it not for family pressure, the soldier would be able to function normally within the army. As the external pressures are felt, the soldier begins to find difficulty in meeting simultaneously his responsibility as a soldier and the responsibilities thrust upon him by his family. This type of problem is met in endless variety.

In one extreme situation, a soldier was functioning normally and doing an excellent job within the army until his mother, alarmed at the growing sense of independence reflected in the letters of her formerly overdependent son, came to live in the vicinity of the post. From the moment of her arrival, the soldier's work began to deteriorate. He was in deep conflict between his old desire for dependence, reawakened by his mother's presence, and his newly developing sense of independence. So great was the pressure put upon him by the mother that he finally reached a complete impasse. Unable to find any normal solution, he developed a continuing headache to which he attributed his inefficiency.

Throughout this period, the mother, through the Red Cross and through direct contacts with ranking army officers, tried to reëxert her control upon her boy and again to take over the direction of his life, even within the army. The soldier's

condition became so acute as to require treatment by the psychiatrist. With the psychiatrist, the social worker worked with the soldier to strengthen his new independence through a more concrete relationship with army and army authority. Simultaneously, with the coöperation of the Red Cross, he helped the mother to effect the separation that she would have to make if her son were to develop both as a soldier and as a mature person.

Transitions in family rôles while in the army, or shortly before induction, may create for the soldier difficulties in army adjustment. This is particularly apparent among the eighteen-year-olds, who often come into the army at the climax of their adolescent conflicts. The sudden economic freedom and independence from parental authority may prove too complete. Some experience considerable guilt over the new feeling of independence that their military status provides them. In some the reaction is in the form of an internal resurgence of the feeling of dependence.

An extreme example of this kind was a man referred to the worker in a state of complete hysteria, trembling and crying and continuously repeating, "I want my mommy." This soldier was far beyond the assistance of a social worker and had to be referred immediately to the hospital for psychiatric treatment. Another form of this type of reaction may be seen in the uncontrolled behavior of some adolescent soldiers when they go into town and for the first time find themselves free from all control and all authority.

Marriage while in the army, or shortly before induction, may likewise precipitate many problems. For many soldiers, the dual responsibility involved in being simultaneously a soldier and a husband is difficult to carry. Divided in their loyalty between home and army, they find that they cannot function adequately in either.

One soldier, holding a responsible noncommissioned officer's position, upon marriage began to drop considerably in his work. He could not reconcile the demands made upon his time by his wife with the need to devote considerable time, both day and night, to his military duties. The situation became so serious that his commanding officer recommended that he be shipped to another post, and requested the worker's assistance in effecting the transfer.

This situation created a real problem for the social worker in as much as it involved a decision that would mean separation of the soldier from his family if he were to continue to be effective as a soldier. In his civilian practice, the social worker's primary concern was the maintenance of sound and wholesome family relationships. As the representative of military authority, interested primarily in the efficient functioning of the army, his decision might create disharmony within the family. Accepting the priority of military efficiency in time of war, the social worker was able to help the soldier accept the transfer and plan for the return of his wife to her home during his absence.

An important group of problems in military adjustment, not yet considered, are those precipitated by emergencies within the family during the soldier's absence. Faced with such a situation, the soldier has a sense of helplessness and insecurity because of his inability to do anything from a distance. In his frantic attempt to help the family, he may resort to extreme means. One soldier went AWOL and took a civilian job in order to tide over a period during which his wife was critically ill and in need of financial assistance. Had he had earlier recourse to a military social worker, he might have been helped to utilize army, Red Cross, or civilian resources developed to meet just such an emergency.

Sometimes, unable to take such extreme steps and unable to use available resources, the soldier may develop acute anxieties which render him useless to the army. The task of the social worker in such situations is to help the soldier see more objectively the situation within the family and to utilize the various resources of the army and of civilian life in meeting the emergency.

In considering more directly what the social worker can do to assist men who are reacting to the types of pressure that we have discussed above, it is helpful to consider in greater detail a specific case.

> Corporal Keyes[1] came to the writer stating that for the last few weeks he had been feeling extremely nervous and upset, unable to concentrate on his work, and very irritable. It was only after a specific question by the social worker that he could tell of the source of his concern, almost crying as he did so.

[1] All names and identifying details have been changed.

Some time after induction, during a ten-day furlough, he had married a girl who had been his childhood sweetheart. He had spent only ten days with her and enjoyed one of the most idyllic periods in his life. Although return to the army had been difficult, he had been able to go back in the knowledge that he would be obtaining periodic passes to see his wife. Shortly after his furlough, a command policy was established reducing the number of passes. From that point on, he became increasingly disturbed and anxious. He planned to bring his wife to the post, but in the interim his mother-in-law had become seriously ill, requiring his wife to remain and care for her. About a week before the interview, his wife had written him that she was pregnant.

This news had upset him so badly that he had been unable to work. The social worker's question was met by a strong affirmation of his desire for a child. Tears flowed down his cheeks as he described his sense of futility, his feeling that he couldn't do anything, and his concern over his wife, who was so helpless in this situation.

As the social worker questioned him about his wife, he spoke very highly of her and of her achievements. The social worker wondered which he felt—that his wife was as capable as his description indicated or as helpless and inadequate as his concern suggested. Did he feel that his wife was totally incompetent and unable to meet her responsibilities at home?

Corporal Keyes, taken aback by this challenge, asked angrily: "What do you mean by that? My wife has more guts than any one I know!" He then boasted of her capabilities.

The worker then wondered whether, if his wife were really so capable, he was being fair to her in trying to take over so completely her responsibility and denying to her any ability to meet some of her problems herself.

"But what can I do? I feel I should be there helping her and here I am tied down in the army," was the soldier's frantic reply.

The worker commented on the difficulty of being away from his wife at such a critical time. Did he feel, then, that there was nothing he could do to help her?

"Is there?" the soldier asked desperately.

The social worker replied that there were things that could be done. But could he do anything in his present state?

"What do you mean?"

The social worker answered that, distraught as he was, not only was he unable to help his wife, but he would make her more concerned and worried about him as well as about her mother and her state of pregnancy.

The soldier hadn't thought of that. Considerably calmed, he commented that he had been so absorbed with his own concern over his wife that he hadn't stopped to think what she might be feeling about him.

"Come to think of it, her last few letters asked what was troubling me. Maybe she was worried about me!" He seemed somewhat surprised and ashamed.

There was a brief discussion now of how, in a sound family relationship, absence does not mean that the head of the family ceases his rôle in the family. Through letters, through moral support, and through

various things that he might do through the army, he could continue to be of real assistance to his wife and family.

This led to a discussion of a more concrete means whereby the soldier might help his wife and family. When the worker asked whether he had used the Red Cross, the soldier reacted strongly, saying that he wanted to do this thing himself and that he needed no help from any one. The worker commented that it was hard to take help, but in speaking to the worker now about his problem, wasn't he really doing something to help himself?

This was different, the soldier insisted; his family had never taken relief and was independent.

The social worker wondered whether, in this instance, the use of the resources of the Red Cross and the Army Emergency Relief meant "taking charity" or whether it was not using something to which he was entitled by virtue of his being in the services.

But he wanted to do this alone, the soldier insisted.

Actually, though, weren't the agencies *his* agencies? They could come in only at his request—to represent him, so to speak, in his absence.

The soldier said that he hadn't thought of it that way; he might be able to use the Red Cross.

The worker wondered how his wife would feel about that. The soldier felt certain that she would avail herself of whatever help he could offer. He would write her and suggest that she get into touch with the agencies about prenatal care and financial assistance if necessary.

The worker commented on the change in him; he talked now as if his wife had a head on her shoulders and could do things on her own. The soldier smiled and said that he wouldn't have married her if she were helpless. The worker remarked that there were two of them at work now on their problem.

The soldier requested detailed information about the various resources available for assistance, about the location of the Red Cross and the procedure for applying to the Army Emergency Relief. After giving him the information, the worker remarked that he seemed to have control of things now. The soldier marveled at his diminished concern. The worker suggested that he come back if anything else came up.

Some weeks later, the soldier returned to state that he had written his wife about the resources available, and about the possible use of the Red Cross. She had, herself, then gone to the various agencies, made plans for her prenatal care, and, with the assistance of the Red Cross, had been able to provide some care for her mother. He was grateful for the help we had given him and wondered now how he could have possibly reached the state he had.

The worker pointed out that becoming a husband, and a father, was no easy matter even in civilian life. It could certainly be a headache in the army.

"And do I know it!" interjected the soldier. The worker commented that the soldier seemed to be managing both jobs well.

During the remainder of the interview, the soldier chatted about his home, his wife, and plans for the baby. He felt, now that he was again on the job, that there were good possibilities for promotion. If things

went well, he might be able to bring his wife and baby out to the town near the post.

The social worker cautioned him about the uncertainties of army life. The soldier felt he could take care of that when it came. He then conjectured as to the characteristics of the baby, hoping that it would be a girl and look like his wife. The social worker commented that he was really ready now to be a father and wished him luck.

This case reflects quite clearly the degree to which family responsibilities and the problem of assuming family rôles affect an individual's functioning as a soldier. Corporal Keyes was unable at first to differentiate his own rôle from that of his wife. He felt the need to carry the entire responsibility for both of them. Even as a civilian, that load is too much to carry. For a soldier, it was impossible. It is little wonder, then, that he developed the anxiety that he did. As the social worker could help him to objectify his problem, he could help him to separate his own responsibility from that of his wife and leave some of the responsibility to her. The soldier then could approach more realistically what he himself could contribute to the situation. When he began to feel that there was something he could do, his anxiety and sense of inadequacy diminished to a point where he could actually take real responsibility and begin to think concretely of planning and helping in the whole situation.

His reaction to the use of the Red Cross and other resources was typical of the reaction of many men in the army. It is no different from the reaction toward relief or the use of agency help met in civilian life. The use of such resources represents a threat to them. They feel that the "intrusion" of such agencies reflects on their own adequacy, and that to use them constitutes an admission of failure in meeting their responsibility. The approach of the military social worker to that attitude is essentially the same as that of the civilian worker. Assistance by a social agency, whether military or nonmilitary, is actually something the individual himself is using in meeting his own problem. Where he can be helped to see such assistance as something that he himself is doing, as part of his own willing, then he can accept it, use it, and derive from that use a sense of adequacy and growth. In this situation, it was Corporal Keyes's capacity to use such assistance to give his wife the specific information which she needed in solving her problem that again gave him a sense of ade-

quacy and a feeling that he had a real place in the family constellation.

As we consider the rôle of the military social worker in this and in similar situations, certain of his contributions become clear. The social worker serves as an outlet for the expression of many feelings and reactions that, within the coldness and authority of military living, it might otherwise be difficult to bring out. As a representative of the army, the social worker can allow the soldier to measure his personal problems against military needs and to find a means of meeting them compatible with his responsibility as a soldier. The social worker can clarify the course of action that can be taken and can help the soldier to separate out from the confusion of his problem certain things that he can do to meet his problem. Once definite action becomes possible, the sense of futility disappears.

Through his understanding of resources, of the psychology of taking and using help, and of the problems of military living, the military social worker can help the soldier utilize the resources that are provided by the army. By virtue of his relation to military authority, his sensitivity to the individual soldier, and his knowledge of family dynamics, he can help the soldier to orient himself within the army while maintaining his orientation within the family.

While this discussion has, of necessity, been brief and sketchy, we have seen how great the influence of the family can be. We have seen how the forces within the family, and the soldier's relation to these forces, can affect his adjustment to the army. Adequacy within the family produces adequacy within the army. Where the soldier has had difficulty in family adjustment or where new problems arise within the family, difficulty is created within the army.

The military social worker's contribution to a person with such difficulty grows from his relationship to military authority, his sensitivity to the individual soldier and his feelings, and his awareness and understanding of family dynamics. Combining such knowledge with a skill in working with individuals, the military social worker has been able to help soldiers to adjust to the army while at the same time maintaining their relationship to the family.

THE HOSPITAL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN*

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PSYCHIATRIC hospitals for children are such recent innovations that they may still be considered in the experimental stage. The first children's unit in New York State was established in 1924 at the Kings Park State Hospital, to care for children who suffered from post-encephalitis as a result of the epidemic of that period. The unit was designed primarily for custodial care and habit training. Later, children's wards were set up at the Psychiatric Institute,[1] at Bellevue,[2] and at the Rockland State Hospital,[3] to treat behavior disorders, neuroses, and psychoses in juvenile patients. The facilities at Kings Park[4] were expanded to include functional as well as organic mental conditions.

Few coördinated attempts have been made to standardize techniques of management or therapy. Experiences in the handling of average children in foster institutions, of mental defectives in state schools, and of delinquents in correctional units are valuable, but by no means can they be considered completely appropriate for the emotionally disturbed child.

* Presented at the third forum discussion on "Present-day Needs in Advancement in the Mental Health Care of Children" under the auspices of the Association for the Advancement of Psychotherapy, San Remo School, New York City, February 29, 1944.

[1] See "A Service for Children in a Psychiatric Hospital," by H. W. Potter. *Psychiatric Quarterly*, Vol. 8, pp. 16–33, January, 1934.

[2] See "The Organization of a Ward for Adolescents in Bellevue Psychiatric Hospital," by F. S. Curran (*American Journal of Psychiatry*, Vol. 95, pp. 1365–88, May, 1939). See also "Group Activities on a Children's Ward as Methods of Psychotherapy," by L. Bender. *American Journal of Psychiatry*, Vol. 93, pp. 1151–73, March, 1937.

[3] See "Organization and Function of the Children's Group of Rockland State Hospital," by F. F. Tallman. *Psychiatric Quarterly Supplement*, Vol. 12, pp. 175–88, July, 1938.

[4] See "Child Institutionalization as a Psychotherapeutic Procedure," by L. R. Wolberg. *Psychiatric Quarterly Supplement*, Vol. 18, pp. 167–78, July, 1944.

Knowledge that growing children must gratify essential psychological needs as fully as physical needs has directed efforts toward organizing psychiatric units in accordance with concepts drawn from the fields of mental hygiene and social case-work.[1]

A prime requirement in any children's institution is an atmosphere of physical and emotional security, for a wholesome and well-integrated self develops best on the bedrock of security feelings. There must be a minimum of situations that result in physical and emotional deprivation, that frighten or threaten the child or rob him of his self-respect. A general attitude of acceptance must prevail, and the child must be shown that he has rights and needs that can and will be met with fairness and tolerance. Furthermore, the child must be provided with opportunities to develop his artistic and creative capacities. School instruction, vocational guidance, and occupational therapy[2] are important ways of expanding his intellectual development and latent talents.

There are many children who have been reared in environments so destructive that transfer to an institution that provides them with a minimum of mental-health requirements opens the floodgates of self-development. Very young children and those whose problems issue from very disturbed home atmospheres may be materially benefited. Thus a child who is removed from an overprotecting or a rejecting parent or from a violent or hostile neighborhood may clear up remarkably in the relative security of the institution.

Unfortunately, by the time the average child comes to the hospital for therapy, his difficulties have been structuralized so deeply that he continues to react to the hospital environment as if it were a replica of his home. Despite all efforts to make him feel secure and self-sufficient, the compulsively dependent child may continue to cling to protecting adults or to other children as if he has no personal resources that would enable him to stand on his own feet. The child with

[1] See "Mental-health Needs in Children's Institutions," by S. Foster. MENTAL HYGIENE, Vol. 22, pp. 57–71, January, 1938.

[2] See "The Place of Occupational Therapy in Dealing with Problem Children," by F. F. Tallman (*Psychiatric Quarterly Supplement*, Vol. 11, pp. 201–05, July, 1937); also "Some Special Considerations in Occupational Therapy for Maladjusted Children," by A. Krider (*Bulletin of the Menninger Clinic*, Vol. 4, pp. 23–7, January, 1934).

a power drive will compete fiercely with other domineering children and attempt to establish himself in a position of supremacy. The timid and detached child will shy away from all contacts with others despite all efforts to ease him into group activities and play. The masochistic youngster will provoke situations in which he can be beaten unmercifully. Indeed, the child's problems appear to be generated from within and the manipulation of his environment seems to make little difference in his compulsive drives.

At the start, the child's hospital experience may be very traumatic to him and may stimulate his customary neurotic security patterns. Wrested from his home and his family, which constitutes the only security, little as it is, that he has known, he is plunged into a strange and terrifying environment with barred windows, children more aggressive or disturbed than himself, and adult attendants he never has seen before. He awaits and dreads phantasied torments for his infractions of discipline. Whatever self-esteem he has left is pretty much shattered when he realizes that he has, through his own "badness," been brought to the place that has been so often held out to him as a threat. The emotional turmoil that initially fostered his behavior disorder is enhanced a thousandfold by this new calamity.

It is in this situation of inner chaos that we must reach the child and convince him that he is not destructive or bad, that we desire to provide him with an experience from which he can creatively participate in his own growth and find in it a more livable self.

Psychotherapeutic methods employed in children's institutions vary. The recognition of the rôle of unconscious conflict as a dynamic factor in motivating abnormal reactions in childhood has directed many workers in child psychiatry toward the elaboration of techniques for discovering and enucleating unconscious motivating factors. Among these techniques are play therapy,[1] verbalization and story telling,[2]

[1] See "Play and Psychotherapy," by L. Bender and A. G. Woltman. *The Nervous Child*, Winter, 1941–42, pp. 17–42.

[2] See "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children, Part I: The Story, A Form of Directed Phantasy," by J. L. Despert and H. W. Potter. *Psychiatric Quarterly*, Vol. 10, pp. 619–38, October, 1936.

the use of plastic materials [1] and the analysis of the child's phantasies, dreams, drawings, paintings, and other artistic creations.[2]

The therapeutic value of the child's interpersonal relationships with the physician, with the personnel, and with other children has led to the elaboration of group projects in the form of puppet shows,[3] music and dancing projects,[4] collective art projects,[5] and dramatics.[6] Potter [7] and Allen [8] have emphasized the importance of direct interpersonal psychotherapy between the patient and the child. This phase of treatment has been excellently summed up by Gitelson [9] as follows:

> "The aims of the child psychiatrist during the course of treatment may be summarized as follows: (1) to decrease the feeling in the child of being exceptionally or irretrievably bad; (2) to introduce an attitude of self-tolerance with regard to anxiety arising out of conscious hostile, aggressive tendencies that have a natural sanction in the situations in which they arise; (3) to supply lacking information at propitious moments when the child's anxiety comes from obvious ignorance; (4) to clarify, where possible, conscious conflictual relationships in the immediate life situation; (5) to dispel, through the influence and new example of the psychiatrist himself, as a stable, reality-oriented personality, the

[1] See "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children. Part II: Using a Knife Under Certain Conditions," by J. L. Despert. *Psychiatric Quarterly*, Vol. 11, pp. 111–30, January, 1937.

[2] See "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children. Part IV: Collective Phantasy," by J. L. Despert. *Psychiatric Quarterly*, Vol. 11, pp. 491–506, July, 1937.

[3] See "The Use of Puppet Shows as a Psychotherapeutic Method for Behavior Problems in Children," by L. Bender and A. G. Woltman. *American Journal of Orthopsychiatry*, Vol. 6, pp. 341–54, July, 1936.

[4] See "Group Activities on a Children's Ward as Methods of Psychotherapy," by L. Bender, *loc. cit.*, p. 1161.

[5] See "The Use of Art Technique in Treatment of Children's Behavior Problems," by J. Levy (*Journal of Psycho-Asthenics*, Vol. 39, p. 258, 1934); also "Art and Therapy in the Mental Disturbances of Children," by L. Bender (*Journal of Nervous and Mental Diseases*, Vol. 86, pp. 249–63, September, 1937).

[6] See "The Drama as a Therapeutic Measure in Adolescents," by F. J. Curran. *American Journal of Orthopsychiatry*, Vol. 9, pp. 215–31, January, 1939.

[7] See "Psychotherapy in Children," by H. W. Potter. *Psychiatric Quarterly*, Vol. 9, pp. 1–14, July, 1935.

[8] See "Some Therapeutic Principles Applicable to Psychiatric Work with Children," by F. H. Allen (*American Journal of Psychiatry*, Vol. 94, pp. 673–80, November, 1937); see also "Trends in Therapy, Part IV; Participation in Therapy," by T. H. Allen. (*American Journal of Orthopsychiatry*, Vol. 9, pp. 737–42, October, 1939).

[9] See "Direct Psychotherapy with Children," by M. Gitelson. *Archives of Neurology and Psychiatry*, Vol. 43, p. 1220, June, 1940.

delusional conceptions of human beings and their relationships that neurotic parents engender; (6) to point the way to compromises with realities that are inevitable. By this is meant that the child, after all, must live during and after the treatment in a neurotic environment. This is the outstanding reality. The psychotherapeutist needs to work through with the child the fact of the difference between the treatment situation and the environment. The child must be taught that the sense of inner freedom which the therapeutist helps him to acquire in relation to himself can continue to be a criterion for his emotions, but not for his overt acts.''

More recently a general recognition that groups can activate vital social forces within the individual has opened up the possibilities of living together as a psychotherapeutic experience. Slavson [1] has shown how the character structure of children with behavior problems can undergo change through interaction in the permissive environment of a community club. Elsewhere the present writer has outlined some common reactions that occur among children hospitalized in a mental institution, and has indicated that the interaction of children on one another and their experiences in relationships with the ward personnel can play a significant rôle in their personality growth.[2]

Of prime importance is the organization of the hospital environment so that the child will be able to express his impulses freely within the limits of reason and safety. A permissive atmosphere must for the most part prevail, and disciplines, if and when they are administered, must be mild and applied without rancor or rejection. The patient must feel that he is accepted as he is and that he can express his impulses without the loss of love.

The relationships that the child establishes with other children and with the personnel are a reflection of his character patterns. At the start, the child will throw up his usual defenses against people or seek to exact his inordinate demands. His compulsive clinging, his aggression, his withdrawal and detachment will eventually come out. He may regard the group as an encroachment on his own private rights or as an attack on his independence. He may be exorbitant in his expectations and express hostility when

[1] See *Introduction to Group Therapy*, by S. R. Slavson. New York: The Commonwealth Fund, 1943.

[2] See Wolberg, *op. cit.*

these are not indulged. He may seek to wield power or to render himself dominant over the more helpless children around him. His characterologic strivings are vital to him and serve the purpose of protecting him from helpessness and menace.

A very important effect of the permissive environment is that the child eventually rebuilds his attitudes toward authority. Many of the child's problems are rooted in a disordered concept of authority as unreasonable, overwhelming, or punitive, and his feeling is that retaliatory punishment automatically awaits an expression of his strivings. The idea that there are adults who are loving and accepting and who do not threaten him with abandonment has a signal influence in altering his attitudes toward authority as directive rather than punitive.

Living together with other children and experiencing their inordinate demands and aggression sometimes brings a child around to a realization of his own compulsive drives and may motivate a mutual repression of aggressive activity. One may see developing among individual members of the group a gradual feeling of cohesion, a participation in group responsibilities, and finally—after a period more or less prolonged—attitudes of helpfulness and friendliness toward other children. It is very gratifying to see power-driven, egocentric, and destructive children suddenly take an interest in the more helpless children around them, helping them dress or leading them to the dining room.

The actual experience of living together with other children in a permissive atmosphere gives the child an opportunity for an active participation in his own development. Whatever spontaneous forces of self-sufficiency remain in the child, they are liberated best in an atmosphere in which the child can relate himself freely to others. Within the group itself, the child seeks status and recognition, and these eventually are sought through coöperative rather than individualistic enterprises.

It must not be assumed that the permissive hospital environment necessitates a suspension of all discipline. A great many children with behavior problems seen never to have devel-

oped an inner system of restraint that makes it possible for them to inhibit aggression or to tolerate frustration of the slightest kind. An atmosphere of unlimited permissiveness may actually incite these youngsters toward greater demonstrations of aggression, directed at other children or at the personnel.

Firm, but kindly disciplines applied to the child by the adult with whom the child has established the seeds of a loving contact aid him in developing essential repressions. The child must be shown that he is accountable for his own acts and that definite things are expected of him. In most cases he will at first rebel and attempt to break down the limitations on his behavior. But as soon as he accepts the fact that there is an adult who understands and approves of him despite his "bad" behavior, he will be motivated by a desire to win the love and approval of this adult, even though this involves an inhibition of his aggression and his destructive activities. A fear of losing love and approval has, on the whole, a more potent effect than severe disciplinary reprisals.

An objection may be voiced that group interpersonal experiences, while beneficial, really are superficial and do not touch the deep, dynamic problems of maladjustment. Since difficulties are often rooted in the experiences of the past, the only rational approach would seem to be the uncovering of early conflicts. This argument is not entirely valid, for the present-day impulses and tendencies of the child do not operate in a vacuum isolated from the past. In his present interpersonal relationships he recapitulates his fears and anxieties.

As a matter of fact, attempts to deal with emotional problems in children on the basis of analysis of their deep inner conflicts are often quite disappointing. We may discover the child's conflicts through play therapy and present them to him, but they are usually very vague and nebulous discoveries which he might possibly accept, but rarely will carry over into terms of present-day realities. His security may have been undermined and his self-esteem crushed during infancy, but it is the present world that is menacing to him. He lives with the ghosts of his past, but not in the past. His

present-day world contains the nuclei of his past, and we can work with his present-day relationships and from them actually unravel his earlier conflicts.

For instance, the child may have an inordinate need to be preferred and to be praised above other children on the ward. Play therapies lead to the discovery that a competitive attitude exists toward a younger brother. This revelation has little therapeutic effect on the child until he begins to appreciate that his reaction to his present playmates are the same as if they were all hateful little brothers. Thus, the child lives mostly in the here and now and not so much in the past, and whatever sources have molded his character structure have already shaped his destiny. They must be dealt with in his present world. An analysis of his interpersonal relationships from day to day is, therefore, not as superficial as one might assume.

Group interpersonal therapy necessitates a rigid selection of personnel, for the adults who surround the child can have a detrimental or a liberating influence on him. An adult in contact with emotionally disturbed children must have qualities not possessed by the average ward attendant. He must be sufficiently secure within himself not to respond with retaliatory rage or rejection to the aggression and impudence displayed toward him by a disturbed child. The automatic need to enforce authority for authority's sake may be a culturally accepted practice, but scarcely one that can aid the child in redirecting his attitudes toward adults. The hospital attendant must be sufficiently integrated not to have to demand obedience and conformity without qualification. His position of leadership necessitates a philosophy of life that enables him to accept the child as an individual with rights, even though the child responds with abuse. This does not mean that the adult must pander to the child. Adults who use children as an outlet for their own emotional problems, overprotecting or clinging to them, thwart the children's self-development and inhibit their personality growth.

An essential part of the treatment of the child involves some provision for an environment, in the last stages of therapy, that is more realistic than the permissive environment in which he has been treated. Up to a certain point

in his development, the child must be reared in an artificial environment. In no sense of the word is it one in which he is subjected to realistic demands and pressures. The warmth, the permissiveness, and the kindliness extended to him are such as he could not experience in the world of reality. Indeed, in the realistic world his impulses have alienated him from people and have brought upon him all manner of retaliatory response.

The artificiality of the permissive hospital environment was necessary at the start for therapeutic reasons, in order to build within him a sense of security and inner strength. But permissiveness and unlimited understandings are not the keynotes of the outside world in which the child must eventually live and function. To halt therapy at a point where the child relates himself congenially to the adults and children on the hospital ward is only a partial solution. He must be exposed to and he must learn to accept the standards and disciplines that are patterned after the mores of culture. He must attain to a character structure that will enable him to operate efficiently in society with all of its unfairnesses and shortcomings.

Some provision, therefore, has to be made within the hospital framework for an environment which approximates that of the outside world, in which the patient may be subjected to realistic demands and expectations. Unconditional acceptance may actually be a handicap in later stages of treatment, for the child may be wooed into thinking that he can do as he pleases without offending his peers. He must learn that he can comply with reasonable authority without hostility or need to submit or ingratiate himself compulsively. He must learn that he can attain to self-sufficiency and independence and can relate himself coöperatively to the world and to other people without fear of disapproval or injury.

PROBLEMS OF EDUCATION TO-DAY *

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FEW, if any, of us can escape the haunting feeling that somehow or other the world's present troubles could have been averted by education. Even those who most surely see geographic or economic causes for our plight recognize that in the final analysis it is what these things *mean* to *people*—rather than the things themselves—that are important. I have no intent, even if I had the ability, to cover the whole area of a made-over education. However, it is possible, if one talks with a great many children, to evaluate certain matters that seem important and that, up to now, have been the subject of relatively little discussion. These five "problems" I should like to present—in the spirit of a psychiatrist's report on clinical material.

I find serious confusion as to the relation of discipline to freedom. Across our banners is written, "Freedom"; the Atlantic Charter guarantees it; we fight the world round for it. But each of us knows that, without discipline, freedom is dangerous—and we bitterly complain that our children are undisciplined.

If I now define this relationship, it is not to bind your future evaluation, but rather that we may think together. One of the ways in which we can think of life is in terms of levels of integration. Even the atom is complex, but not so much so as the molecule. The organs of the body are integrated into a more complex set of interrelationships in the body itself. This in turn combines with various other evaluations to be the personality, and so on—in a progression that is easy for the educator to envisage because it is represented in his various "subjects"—as chemistry, physiology, psychology, sociology, and so forth.

* Presented at Westtown Alumni Old Scholars Day, Westtown, Pennsylvania, May 27, 1944.

Discipline must occur at every level of integration (or evaluation) in order that there may be freedom at the next higher level. Any level must know what it can count on, must have sure-footing as to the performance of lower levels if it is to be free. If one disciplines the appetite that it may become habituated to ascetic ways—where is freedom? But if the appetite is ordered so that the body can act in certain ways—then, indeed, discipline implies freedom. If we discipline the muscles, the person can run or leap. If the soldier is disciplined, the army is free to attack. If the nation is disciplined, there can be international comity.

Here, I feel, we have made some pretty bad mistakes. We have had some kind of nebulous notion that discipline and freedom can occur concurrently and at the same level. It is this that has led to so much discipline for discipline's sake. We have used flash cards for years in the primary grades. For what? Well, the children learn that it is to enable them to add more quickly. I can count on my fingers the children who have any conception of the fact that the purpose of the discipline of flash cards is that there may be freedom in doing problems. And there are an equally small number who have seen a glimpse of the freedom to roam the world that is inherent in the discipline of learning to read.

The same problem at the high-school and college levels would demand volumes to cover the bitter struggles that have gone on over the matter of electives. If, with the holoists of to-day, your goal is the educated man, then you must impose discipline at the level of the building stones of that structure. If you rigorously impose four years of Latin merely that the individual can the better study Chinese, you have only meshed your feet in the problem of transference. But if this is done that the student may feel sure-footed as to his mind as a means to this or that end, then you are on the road to freedom for that individual.

These are not difficult matters to get over to the student—at whatever level. Here is the old problem of motivation, but with some new implications. Freedom is not to come later; it is not to be found somehow secretly hidden in discipline; it is not to come in some coördinate area. It is here, now, through discipline—at a higher level of integration. You

see it beautifully on your athletic fields where children slave willingly at endless training because this gives them freedom to win the game.

We discipline the poll parrot for perfection at the level at which he is disciplined. We've done an enormous amount of the same thing in education, even up through the postgraduate level. But discipline can mean freedom—indeed one has freedom of attainment at any level of integration only in so far as that level *knows what it can surely count on* from the levels "below" it. A great deal of the license that now worries us comes from our having given—even to very young children—the notion that discipline is somehow to be rewarded by freedom at the level of the area disciplined. So, being wise, they take that freedom while they can.

We need not here set out to explore all of the present concepts as to the nature of the world in which we live just to discover that they differ radically from those that prevailed only fifty short years ago. Most of us were taught about space—and about matter, which occupied certain areas of that space. Energy was a way in which matter acted. But now we see these terms as different evaluations of the same thing. Clean-cut dichotomies are gone. "Either-or," "Something either *is*, or *is not*"—these are gone too. Reality, as we now understand it, cannot be expressed in words; it never existed in any other terms than those of the description of the process by which it could be measured; and these descriptions can now be made only as mathematical formulæ.

And if we turn from the physical reality that is about us to the social reality of our human interrelationships, we end up at the same place. Up to one hundred years ago, most human relationships were on a personal basis. Now, at least in the field of making a living, they are chiefly on a non-personal basis. There has been imposed upon our whole social structure, cutting down into it as a wedge might, what we might call a technical structure. Here once more the terms and concepts of mathematics serve as the only valid means of communication. I would challenge you, for instance, to express clearly in words the wages that the steel-worker John Jones should receive. I'll admit that we are still *trying* to do this with words, and would say that this is the main

reason for the inefficient and fratricidal strife that we have through our present-day industrial structure.

When people can use mathematics as a way of comprehending the physical and technical reality in which they live, they will still want higher wages and shorter hours of work. But the decisions will then be based on causation as correlation, the weighing of variables, varying certainties of predictability. In other words, a new language beckons our adoption if we are to move to better understanding of one another.

Here, once more, we've made some pretty bad mistakes. Mathematics has been only the handmaiden to various of the sciences and engineering. There are only scattered situations in which children are learning why you use numbers—what are their limitations and their usefulness. I'll admit that in the last generation a number of so-called "progressive" schools have substituted pieces of pie or Columbus' ships for the dry and uninteresting marks on the blackboard. But as long as these steps are taken merely to get children to patter off their number combinations more swiftly, we still have discipline for discipline's sake. Discipline in mathematics does not lead to freedom until its various exercises lead us to a better facility in communicating as to the nature of the physical and social reality in which we live.

One does not advocate the teaching of Einstein's theories in the first grade. But when our school faculties begin to understand that reality can be best expressed and discussed in mathematical terms, we can confidently expect that even arithmetic will cease to be discipline for discipline's sake—hated, misunderstood, grimly borne by most of our children.

It isn't easy to-day to say anything new or startling as to the relationship of symbols to reality. We all know that real experiences are idiomatic—unitary. The experience of my saying this word to you at this time will never be exactly repeated. Equally, we know that this fact imposes upon us an intolerably heavy burden in the matter of communication. So we develop symbols. These are obviously abstractions from these various unit experiences. This is necessary. But as our relationships become more complex and the distances over which communication must travel become greater, we must depend more and more upon these symbols. Their importance has grown by leaps and bounds since the inven-

tion of the printing press—and particularly over the last one hundred years, until we now endow the symbol with reality.

Money has gone through the same development. In our minds it is quite as real as a bushel of wheat—for many *more* real. Money, as words, lays its heavy hand on years that are strangers to the experiences that first gave meaning to the symbol. Note how we squirm under the terms "Communism" or "Red." In a few years these had become realities, to be thrown at anything we did not like. To-day, like tomatoes in our hands, we are puzzled as to whether to eat or hurl them. "Nazi" only so short a time ago was a specific short-hand term for a specific movement. To-day, a magic wand, it breeds hatred against anything it touches in human thought or relationship.

In education our children get no picture of the relationship of words to reality. We teach facility, we teach them to read at hundreds of words per minute, we teach rules of order and sequence. But few children whom I see—and I confess that this also goes for adults—have any conception as to whether these words are slaves or masters.

This does not mean that we should do away with words any more than that we should return to a barter system just because our medium of exchange for the moment seems to create more problems than it helps us to solve. But it is a plea for enough reorientation of education to insure that, from the kindergarten on, children be taught why we use words. Suppose that we dedicated ourselves for some years to teaching the limitations rather than the glories of language! Each one's life is a unique work of art. One knows that one's richest and most meaningful communications are those without words. The hand laid in tenderness or anxiety—or anger—molds or decorates as no lexicon could. Descriptions embellish, money says something of relations in value, but it is the lighted face or the heavy step that are the realities.

These things we can teach our children and adults. This is not to the end that symbols may be given up, but that they may be as far as possible just symbols.

Our education invokes what it is pleased to call "the scientific method." This, in 1944, means that even at the kindergarten level we would have our pupils question everything,

believe nothing that they cannot prove, build everything with cold logic. The fact, as we shall see in a moment, that this is not the scientific method did not prevent its borrowing prestige from the last century's sweep of enthusiasm for science. It is only fair to remind ourselves that even in the eighteenth century, the surge of the concept of democracy as a form of governance was based on this same notion—that the problems of human relationships could be worked out on an intellectual basis. Those French philosophers who so deftly mortared the stones of democratic structure had every faith in education, believed that knowledge is power, that it should be cold and certain, that through it our problems have their solution.

But this is not so. Not the simplest of scientific experiments but rests upon an hypothesis—as the intricate symmetry of geometry falls to tangled chaos if not supported by the axioms. Hypotheses, axioms—those things that we accept without the need of proof! Axioms, values, faith—the word is not too important.

Many of those with whom I work seem to *me* to have false or weak or tricky values, but possibly it is they who are right and I, wrong. This doesn't represent the serious problem that I see in so many who have no realization that life must be built on one or another set of values. Life, like geometry, crumbles to dust if it is not based on certain things that one assumes without the need of proof. Knowledge is a sharp tool in the artisan's hands, but it is no more power than chemistry is the elements or physics, energy.

Here once more one calls to education for reorientation. Couldn't we stop, even at the kindergarten level, saying, "If this is so, then such and such is so," and begin now to say, "If this is so, then on the basis of our assumptions such and such is so"? And couldn't we carry this to the highest of our postgraduate degrees, even if it were only an oft-repeated phrase meaning that over and over the student felt how empty his world, how meaningless, without values?

Certainly there is no other group before whom I could more comfortably affirm my belief that it is not our right or responsibility to impose *certain* values upon others. Nor is that the matter that is involved here. But there is every compelling

reason in these years to point out to the child that life and its items can have meaning only in so far as they are built upon values. It would be fascinating to stop at this point to ferret out those many devious paths that have led to the high road along which my children travel—a road lined with bazaars hawking every conceivable bauble, for which the child has no use because he has no plan into which these can be fitted, no design for living. But that we must leave. The fact is here—strengthened each day a hundred times by the school's insistence on knowledge and logic, forgetful that, imperative as these are, they are meaningless jargon unless fitted into a pattern that is fashioned of "those things which we accept without the need of proof."

To-day one word is on each man's lips, in every prayer, its search the quest of all—Peace. Schemes and plans abound, nor do I intend to add one more blueprint. One thing can be said to American education—it is not the whole matter, but it is important. As over these next months we watch the great ones sitting in conclave making this or that allotment, might it not be worth our while to look for a moment to One Who, I think we would all agree, lived and died in peace. He didn't have a single one of the "freedoms" that we so nobly talk of to-day, but His words ring down through the ages to drown any document or international agreement you or I know: "Peace I leave with you, My peace I give unto you; not as the world giveth, give I unto you." Two things seem clear to me in the life of Christ as it is recorded. He had clearly a set of values and He led his life on the basis of those values. If you are one of those modern who squirm at the sound of old words, here was One who had integration of the personality.

American education touches every child for ten years and many for a much longer time. These are the years above all other when the individual becomes conscious of his own choice as to his values—his faith, if you will. Each of us who knows children at all knows the clearness of those values if they are found, their stubborn resistance to compromise, their forthright demand for expression in life situations. And what do we—what does American education—do about this?

Well, we teach about democracy, all the time maintaining in the school structure about the most authoritarian sector of our whole cultural pattern. We endlessly talk responsibility, but show me one school where children are given freedom to make wrong decisions. We shout brotherhood and love of fellow man in the setting of report cards or other measuring rods that well nurtures cutthroat competition. The schools talk to-day a great deal about guidance—and one finds it thought of as a newer and subtler means of steering the child to a more placid conformity with the world about him. As long as this goes on, the psychiatrist would assure you that there can be no lasting peace.

Admittedly, I am not talking about such a peace as the world giveth. I ask American education to help youngsters see the need of a set of values and then help them in finding ways in which they may live these out. I see a good many adults as the parents of my patients. Many have failed to see the importance of values, but far more are those who have long since hidden their values away in the name of "adjustment." As long as that goes on, we will not have peace.

It is not fair to say that this is entirely a school problem. But those of you who intimately touch the child from six to sixteen or twenty-two view the golden years of development —or not—of integration. If we were to spend this time helping the child to build his house on his foundations instead of making it fit our drawings—well, our schools would be less comfortable places, they might even forfeit some of the alumni interest, but this is the way to peace.

There would have been a number of more pleasant things to talk about to-day—the items of bringing up children in these higgledy-piggledy times, new gadgets in the field of guidance or personality development. I've tried to stay at the level of what my own patients say to me about the situation in which they find themselves. I would guess that if truth be told, we don't think any more highly of the world we have made than they do. There are many things at hand to be done. I've spoken of but five, but they would seem to me to represent at least a fair start.

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THE RELATION OF THE MENTAL HOSPITAL TO THE COMMUNITY*

CARROLL A. WISE
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SOME time ago I was consulted by a young nurse who, after taking training in a general hospital, had accepted a position on the nursing staff of a large mental hospital. After almost one year in the mental hospital, she found herself in a conflict. Her family were insisting that she give up her position. They kept telling her that a mental hospital was no place for her to work, that she could not learn anything there, and that they were afraid that she would become queer if she continued in her position.

On the other hand, her own experience told her something quite different. She was amazed at what the mental hospital had taught her about the human mind, about life, and about illness. She had come to an understanding of her patients that had removed from her mind the unreal and unfounded fears that plagued her parents. And she had gained considerable insight into her own personality and had not the slightest fear of becoming "queer."

She was a very intelligent girl and had caught something of the meaning of mental illness in relation to the total life of the community. She knew that the attitude of her parents was shared by many others, but she could not accept this attitude. Instead of feeling discouraged, she saw the challenge in her situation as she said, "Something must be done to change the attitude of the community toward mental hospitals."

Any alert person who shares our modern understanding of mental illness feels keenly the problem expressed by this nurse. Let us state it differently: Mental hospitals are the children of the community. They are organized by the community to care for special kinds of community problem that are created in and by the community. This last fact

* Presented at the commencement exercises of the Toledo State Hospital School of Nursing, June 11, 1943.

should be emphasized—mental illness is a product of community life and is a grave responsibility of the community. But the community does not fully and readily accept this responsibility. In fact, in many ways it tends to reject the mental hospital, even as some parents reject children that they have created, but do not want. How does it do this? In a number of ways.

One means of rejection is the fun-poking and disparaging attitude so frequently manifested by members of the community. The mental hospital is a "bughouse," a "crazy house," a place for "lunatics." To enter a mental hospital is, in the minds of many, a sign of disgrace, and the mental patient is often the butt of jokes and derision. These, let it be repeated, are expressions of rejection on the part of the community. The community is forced to maintain mental hospitals because of unhealthy tendencies in its own way of life, and because of its failure to deal adequately with the victims of unhealthy tendencies in community life before extreme manifestations of mental illness appear. But the community has failed to face and to accept the social implications of mental illness. Having placed the mental patient in a hospital, it then proceeds to wash its hands of responsibility and says to the hospital, "Now it is your problem." What are the results of this attitude?

The major result is the isolation of the mental hospital from a vital and organic relationship to the community. The very physical location of many mental hospitals is symbolic of this isolation. Because they require a large acreage for farming and recreational purposes, they are usually located on the edge of a city, where ground is available. But this very physical distance between the hospital and the center of the community makes easy the expression of a damaging kind of psychological isolation in the mind of the public. The hospital is "out there," patients are "put away," the hospital "is necessary, but wouldn't it be nice if we did not have to have it?" These and other such statements express an unhealthy attitude of isolation on the part of the community toward the hospital.

One result of this isolation is the failure to integrate the services of the mental hospital into the life of the community

in any significant manner. Much mental illness begins in childhood, yet how many school systems make a place for the examination of the mental health of their children? Some day we may learn that such an examination may be much more important than the examination of lungs and teeth, even though the latter must be accepted as highly important. Many of the personnel problems of industry, such as inefficiency, are problems in mental hygiene, but what relationship have we developed between the mental hospital and industry? Our schools of higher education abound in floundering, disjointed, and disorganized personalities. Here, let it be said, there is much more intelligent understanding and application of the principles of mental hygiene than in many other institutions of society, but the gap between the college and the mental hospital is still altogether too large.

Again, a similar gap exists in the relationship between the general hospital and the mental hospital. Many physicians who are experts in various kinds of physical illness fail to understand the rôle of mental factors in the causation and cure of many common physical illnesses. Indeed, they look upon psychiatry as something of a freak among the specialties of medicine. But the truth that is being established by psychiatric research to-day is that much physical illness has its roots in the mind of the patient, and that many patients in our general hospitals are mentally ill even though their illness expresses itself through their bodies rather than through their behavior.

Another result of this attitude of rejection on the part of the community is inadequate financial support of mental hospitals. Adequate care and treatment of the mentally ill is expensive business. That fact needs to be more commonly accepted. On the other hand, in the long run, adequate care and treatment are not as expensive as inadequate care and treatment. One of the results of inadequate care is to be found in hospitals all over the country—the large number of patients who with adequate care might have recovered sufficiently to go home. With inadequate care, they fail to recover and become institutional cases for the duration of their lives, supported by the community. Thus the community is penny wise and pound foolish. Adequate care and

treatment is an investment that yields high returns; inadequate care and treatment is an expense that becomes a burden. The finest staff of physicians and nurses cannot function properly without adequate financial support.

To be sure, part of the responsibility for the failure to integrate the mental hospital more significantly into the life of the community rests on the shoulders of those of us who carry on the work of mental hospitals. Often we have lacked vision and courage; often we have succumbed to the temptation to rest at ease within the walls of our institutions, content to let the world go by. We must face these deficiencies in ourselves. And to those of you who this day are graduating from the school of nursing of this institution, let me say this: For three years you have lived and studied here. Because you have been trained in a mental hospital, you have acquired an equipment for your noble profession that the nurse who is trained only in a general hospital sadly needs, but lacks. Because of your training, you have an additional responsibility, the responsibility of helping to make the world a saner place in which to live. Your first responsibility is always to your patient; but your second responsibility is like unto it, for, in a real sense, the community also is your patient.

The mental hospital, then, is the child of the community, but too often the rejected child which is improperly understood and cared for. Let us go on to a consideration of the need for a changed attitude on the part of the community.

In the first place, consider the incidence of mental illness in our country and the economic loss due to mental illness. In this country there are approximately half a million patients in our mental hospitals at the present time. Over one-half of all hospital beds in this country are occupied by persons suffering from mental or nervous disease. The financial cost of maintaining these institutions for 1937 was $230,365,987. It is difficult to estimate the economic loss due to mental illness. A study made in 1937, however, estimated that for that year is was $1,115,177,026.

If we look at the situation in the state of Ohio, we find that to-night there are approximately 20,000 patients in our nine mental hospitals. This figure represents approximately

one out of every 250 persons over fifteen years of age in the state. The cost of maintaining these institutions is approximately $4,000,000 a year.

These figures should serve to underline the fact that, solely from the point of view of the maintenance of hospitals, the problem of mental illness is one of serious proportions for which the community must accept a greater responsibility, and concerning which the community needs to become more intelligent and understanding.

In the second place, consider the incidence of poor mental health in the community. When one with mental-hospital experience speaks of the large number of persons in the community who are in poor mental health, but whose symptoms are not extreme enough to place them in the groups that are legally committable to a mental hospital—when one speaks of these people, many untrained persons immediately take a defensive attitude and, without foundation, assert that the mental health of the community is very good. Let us, therefore, look at some objective criteria, the importance of which only those intellectually and socially blind can deny.

Let us look, first, at the major reasons for rejection of men in the eighteen-to-thirty-eight-year group called up by the Selective Service System. Dr. Thomas Parran, the Surgeon General of the United States, has pointed out recently that two out of every five men examined for military duty are unable to meet the physical and mental standards of the armed forces. The most frequent reason for rejection is eye defects and diseases. The second most frequent reason is mental conditions. That fact in itself should make us pause. And when we add to that the additional fact that a significant number of men who are accepted become mentally ill between arriving at camp and leaving the country, the weight of the problem increases. Says Dr. Parran:

> "The problem of mental disease, now outranked only by eye defects as a cause of rejection, has been largely ignored. In the past our principal method of treatment for such individuals has been to confine them in an institution. The fruits of this policy are now being harvested. There is a great need for a nationwide expansion of research and of preventive mental-hygiene services both in schools and community centers."

Take another criterion of poor mental health in the community—the breakdown of family life. Every worker in a

mental hospital knows that very frequently faulty family relationships are at the basis of the illness of our patients. But look at the record in the community, as indicated by our ever-rising divorce rates and the large number of broken homes that never reach the divorce courts. Such situations may be viewed from many angles, but when they are viewed in terms of the personalities involved, they reveal the ugly fact that the mental health of many persons is so poor that they cannot make the very intimate and personal adjustments required by marriage and family life. Furthermore, we know that the broken home is so damaging to the personality of children that it places a severe handicap on the child and often leads to mental illness in later years. Said a patient to me recently, "I am sure I would never have been here if my father and mother had been happily married." That patient spoke with an understanding that demands respect.

Other objective criteria of the enormous proportions of the mental-health problem in the community could be discussed. We might dwell on the extent of physical illness due to emotional factors. Various authorities place this at anywhere from 50 to 80 per cent of all physical illness. The mental involvement in cases of chronic physical illness—that is, cases in which the patient remains ill for a year or more—is being found to be very high. Or we might discuss the mental-health problem involved in industrial disputes, strikes, and absenteeism. Another tremendous social problem, taking an annual toll in health and economic loss that we can ill afford, is alcoholism. At its root alcoholism is a mental-health problem, and the alcoholic is mentally ill whether he be in an institution or not. Let us, however, consider some of the mental-health aspects of the war.

From the point of view of mental health, the war has both positive and negative aspects, good and bad effects. On the positive side, it has given many people a sense of worth, a real purpose in life, and an opportunity that they had never known before to forget themselves in a larger cause. This is healthy. But it is a sad reflection on American political, educational, and religious life that it should require a crisis that threatens our very national existence to achieve this

effect, when during the past twenty years we have faced social and political problems that are eclipsed in their seriousness and magnitude only by the present threat to our national existence. Yet even to-day, there are many persons in our communities whose mental health and personal integrity are so poor that they pursue an extremely selfish way of life in the face of the greatest crisis that our country has ever experienced.

Consider also another aspect on the negative side of the war, the increase of delinquency on the part of youngsters from twelve to eighteen due to the breakdown of family life caused by the war, and due also to the uncertainty and insecurity in which these youngsters find themselves. One does not need to cite figures on the increase of juvenile delinquency. Our newspapers and magazines are full of tragic stories, and they print only a small part of the whole truth. Here is a mental-health problem of vast proportions, and one that our conventional methods of trial, conviction, and punishment are incapable of handling constructively.

Consider another aspect of the war—the tremendous and difficult emotional readjustments that we will all have to make after it is over No one knows exactly what life will be like after the war, but we can be sure of one fact—it will be different. What kind of emotional adjustments will we make to that difference? What about the emotional readjustments that will be required of the boys who fly our bombers and our fighters and who run our tanks and battleships? What about the emotional readjustments of women who are now in industry, or in the Waves and the Wacs? What changes in our industrial and economic situation will follow the war, and will we be emotionally able to meet them? What about the parents whose boys will not return and the wives and children whose husbands and fathers will not return? These are unpleasant realities, but we know that the health of the future lies in facing them and preparing for them to-day.

In citing these objective criteria of the magnitude and seriousness of our mental-health problem, we do not mean to create fear in the mind of any one. For with all its seriousness, the problem can be handled constructively. But it will be so handled only if it is recognized. And it will be so handled only if the isolationistic attitude on the part of

the community toward the mental hospital turns to one of understanding, and if the understanding is deep enough to bring additional support and expansion of the services of the hospital to the community. Of one thing we may be sure—any expenditure that permits the expansion of a mental-health program to-day, or that will lay the foundation for such expansion, will decrease the larger expenditure that will be necessary to care for the mentally ill to-morrow.

This discussion heads up in a certain fact. Our mental hospitals to-day, with all their internal weaknesses and with the handicap of a faulty community attitude toward them, are of very great actual value to the community. But their potential value is much greater. And to a large extent this potential value waits for community understanding and support in order to become an actual value. What are some of these potential values that need to be developed to-day?

The first is the value of the hospital at the point of curing the mentally ill. Our hospitals are doing a respectable job at this point to-day. But a better job could be done. There are a number of handicaps that could be reduced. One is the attitude of the community toward the individual who has recovered and who is able to leave the hospital The failure of the community to accept a recovered patient on the same basis as it accepts a recovered patient from a general hospital, and the fact that the community places a stigma on the person who has been in a mental hospital, presents a serious obstacle to cure. Every mental hospital has on its wards many patients who could recover and go home if they felt that their family and the community would accept them and give them an even chance. Against such a community attitude the hospital has no effective medicine. The patient has been made ill in and by the community; and the attitude of the community is a powerful factor in effecting a cure.

Consider another community attitude that renders cure very difficult and sometimes impossible. It is expressed in a frequently heard statement from the families of patients: "We kept him at home as long as we could, but he finally got so bad that we had to bring him as a last resort." Considering the mental hospital as the last resort only handicaps

the hospital in effecting cure. Mental illness, to be cured, needs to be treated early—the earlier, the better. Else it may develop to a stage where cure is impossible. The community must learn to think of the mental hospital, not as a last resort, but as its first line of defense against mental illness.

The potential value of the mental hospital in curing the mentally ill needs to be recognized, and proper steps should be taken toward the fuller realization of this potentiality. But consider another potentiality that should be developed into an actuality—the value of the mental hospital at the point of prevention.

The word prevention stands for a process of infinite value, not only in medicine, but in every endeavor to reduce human suffering and to solve our pressing social problems. In regard to mental illness, it is an inescapable emphasis. As Dr. William A. Bryan has frequently said, we cannot solve the problem of mental illness by bricks and mortar, or by building more buildings to house more patients. The present overcrowded conditions in our mental hospitals is appalling to all who realize its meaning. And one answer to this condition is a greater emphasis on prevention. The present admission rate to our mental hospitals must be substantially reduced, and here the community has a definite responsibility.

One way of developing a program of prevention is through research into the causes of mental illness. To-day we know a great deal about the causes of some forms of mental illness. But in regard to the causes of other forms, our knowledge is not nearly so profound nor so complete. There is but one way to gain this knowledge—namely, through an intensive program of study. The mental hospital represents a vast laboratory of human experience in which such study can be made. But this requires an adequately trained and properly supported staff of physicians, nurses, social workers, and other specialists. And a staff cannot be assembled without sufficient moral and financial support by the community. The community should accept financial expenditure for such research as an investment, not as an expense. It is a form of insurance—of insurance against the necessity of building more buildings to house more patients. Every cent spent for research to-day will greatly lessen the burden of caring for the mentally ill to-morrow, and will also greatly reduce

the human tragedy represented by incurable, but preventable, mental illness.

But research in itself is not enough! The facts must be carried to the community in an effective manner. This means education in every sense in which the word can be applied. It means a closer relationship between the mental hospital and our schools and colleges. It means equipping the mental hospital with trained social workers and others whose major responsibility would be that of dealing with the community in a process of education and reëducation. The frequency with which patients discharged from mental hospitals are returned with a recurrence of their illness indicates that in the hospital we are dealing with only part of the problem. The other part is in the community, in homes and family life, in business and industrial relationships, in education and social relationships, and in religion. The patient comes in the first place, and returns, because conditions in the community are conducive to the development of mental illness rather than of mental health. The community must help itself by making it possible for the mental hospital to serve it at the point of education. This is an essential process in a program of prevention, and prevention is our first line of defense against mounting admission rates to mental hospitals.

The utilization of the unrealized potentialities of our mental hospitals at the points of cure, prevention, research, and education involves a change in attitude on the part of the community toward mental illness and toward the mental hospital. It requires also an even more difficult change of attitude on the part of the community, which can only be mentioned and not elaborated here. This is a change of attitude toward itself, and toward its functions. Is the community just a place, in which individuals live, for better or for worse, for illness or for health? Or is it a sense of responsibilty of each person for his neighbor; the development of a relationship between person and person through which the greatest good of each is sought; the organization of group life around meanings and values that make possible the growth of healthy, wholesome personalities? Only in the latter meaning do we have a real community; in the former, we have a disorganization of group life that

produces mental illness, crime and delinquency, family breakdown, and our many other social problems, including war.

Here we come to the basic problem of our social life, and this is essentially a religious or spiritual problem. Only in a community where persons are accepted as the most worth-while products of social life, and where other goals, such as making money, are subordinated to this central goal of creating a kind of community life in which persons may develop to their fullest capacity and achieve their divine heritage, will the closely related problems of mental illness, crime, and war be finally solved. The community must accept the presence of these problems as symptoms of its need of repentance, and change, not merely in organization, but in its very soul and spirit.

Somewhere in my travels I have picked up a parable. It concerns a city built on a high hill. Around three sides of this hill was a steep and dangerous precipice. Now it so happened that people frequently lost their foothold, and fell down that precipice. So the city had to maintain expensive hospitals, and daily the ambulances made their way to the bottom of the precipice to pick up injured citizens. One day some one got an idea. Why not build a fence around the top of that precipice? Why not place guards at the ends of the streets leading to the precipice? Why not place lights around it to warn strangers who went that way at night? To these questions many citizens gave one answer: "These things are too expensive." They did not see that the cost in terms of loss of life and maintenance of hospitals was much greater than that of preventing casualties in the first place. So the people who favored fences and guards and lights were outnumbered and outshouted and outvoted, and the citizens continued to fall over the precipice.

Members of the class of 1943, you are going out of this school of nursing into a sick world. But do not let this fact disturb you unduly. You are going out equipped in hand and mind to serve at a point of sore need and dire distress. And if to this training you add a consecrated heart, you may become one of an increasing number who find their joy in bringing peace and health to their fellow men. Your first responsibility is always to your individual patient, but do not forget that the community also is your patient.

AN EXPERIMENT IN PAROLE AND HOSPITAL EMPLOYMENT FOR THE MENTALLY ILL IN IOWA

M. OPAL FORE

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IN 1941, Dr. Nathan Blackman, now with the armed forces, came to the Clarinda State Hospital as clinical director. He encouraged the other physicians, the attendants, the patients themselves, to think of the hospital as a place of treatment. He brought to the parole staff all convalescents who could possibly be considered for parole. He brought forth people who had been in the hospital for many years, most of whom were in a stationary condition.

Not all wished to leave. One old man from Willow Dale, our farm cottage, who had been in Clarinda thirty years, said, "I don't want to go out. The folks at home are all gone now. I have no other home." And a little old lady, whose relatives in California offered her a home, said, "You people have been so kind to me. I wouldn't want to make a change."

But this stimulation toward parole brought forth many patients anxious to leave. It brought to light good workers on the farm and in other departments, who had been in the hospital, five, ten, or fifteen years—patients who had suffered no disturbed spells for many years, but whose relatives had forgotten them. And occasionally to staff conference would come a younger man or woman whose recovery had been hastened by shock therapy.

We began compiling a list of these patients recommended for parole. In nine months—by September 30, 1942—321 patients had gone out on parole to relatives, transfer, or discharge. But a list of 284 still remained, for whom we could find no outlets.

As there were physicians on the staff familiar with the program of family care as it operates in several Eastern

hospitals, we began to experiment with a substitute for family care in employment to non-relatives. Family care itself was not feasible, as we had no legislation for it or funds to pay the patients' board or to employ supervising personnel.

Capitalizing on the recent demand for labor, therefore, we tried parole to employers and non-relatives. Other states—Michigan, Montana, Arkansas—were placing out details of patients on a temporary basis. But we wanted our people to have permanent employment, with the goal of eventual discharge.

Our first patient was placed out on March 12, 1942. At the end of December, 1943, the period covered by this study, we had placed out twenty-one men and seven women. Totaling their earnings, with farm maintenance estimated at $20 a month, we found that the men had earned $11,736.39 and the women, $2,642.22—$14,378.61 in all.

In every case these were patients to whom relatives and home communities had closed their doors. In most cases counties had been paying for their care year after year. With the cost per patient estimated at $25 a month, the savings to the counties were $5,067.44 for the men, and $1,547.21 for the women, a total of $6,614.65.

Closely related to our program of parole and employment in the community was the employment of twenty-one patients [1] at the state hospital, as a result of the war emergency. Only patients approved for parole who for one reason or another could not return to their local communities were considered. It was, however, not without misgivings that Dr. Norman D. Render, present superintendent of the hospital, and the board of control gave these patients this chance, and a careful study was first made of each patient's history, personality, and illness.

The first patient was employed April 3, 1943. Since then, twelve men and nine women have been employed. The total earnings of these twenty-one patients have been $5,657.96, the men having earned $3,521.80, the women, $2,136.16. The

[1] Three of these patients were included also in the group of twenty-eight in private employment, as they had been in that group before being employed at the hospital. The total number of patients in the two groups was thus 46.

savings to the counties and to relatives have been for the men, $1,188.02, and for the women, $738.32, a total of $1,926.34.

The total earnings in both groups—those in private employment and those employed at the hospital—thus amount to $20,036.57, and the total savings to counties to $8,540.99.

You may wonder what kind of people these patients were.

We remember John, sixty-nine years of age, spry, industrious, usually quiet, maybe a little talkative at times, who had been in the hospital nearly twelve years. He had come in during a depressed period. Through the years his family had seldom visited him; one son was in the army, his daughters were married, and an older son, deferred for farm work, had assumed the father rôle. The wife was adamant against parole. She refused to allow John to come to their county to work for another man, who had agreed to take the parole. She threatened against his coming into any of the neighboring counties.

For many years this man had shown no mental disturbance, always working on the farm detail. After a good deal of correspondence, the local commission agreed to his employment and parole to a young farmer. He went out for $30 a month. At the end of his parole years, he was discharged, as recovered, and immediately got work at $50 a month.

Ed is another chap who has made good. He was forty-three years of age, a tall, jovial, very active man of Dutch descent. He had had an illness characterized by recovery, clear intervals, and a recurrence. As a young man, he had never stayed in the hospital more than a few months at a time, and would then be out for several years. After he returned the last time, he was soon in excellent condition, but his relatives refused to take him out, and he remained for five years. He was another good worker on the farm. The farm manager took his parole. He went out for $75 a month eighteen months ago. Last fall he had saved $900, earning as high as $8 a day shucking corn. He is now discharged as recovered.

There was also the forty-eight-year-old woman who had been in for three years. Mary was trustworthy and quiet, and had shown no psychotic behavior in the hospital. At

one time she had earned $125 a month as forewoman in a garment factory. She had a savings account of $2,000. Her two sisters had filed complaint and one was the guardian. Numerous letters were written the sisters urging parole, and the social worker called on them in their homes, but with no results.

Finally an aged farm woman, living with her two sons, wanted Mary for housework. This woman was mentally alert, and had excellent references, and we closed our eyes to the fact that she was over eighty years of age.

After Mary had worked for two months on leave, we gave parole instructions. Immediately an order came from the court to return her to the hospital, which we did. The next Sunday the two sisters and their attorney came to the hospital, very much excited. We again told them Mary's history in the hospital and the place she had made for herself in the farm home, and finally the parole was approved.

At the end of the year Mary was discharged as recovered. She had earned only a small wage, $3 a week, on the farm, but she had been treated as an equal. Mary appreciated that this old woman had stood by her when her own sisters had turned against her. She was offered a job at the state hospital, and with her experience in a garment factory, she could have demanded high wages in defense work, but she has stayed on the farm with her new friends.

What has happened to these patients—the forgotten men and women—suddenly released to fend for themselves? Most of the men are farm laborers, now scattered over seven counties of Iowa, absorbed into the communities, making good. One young man is a hotel clerk, another a hotel fireman. One was employed in a defense factory in Missouri. One man is working in Chicago; a woman joined her children in Maine; two patients are with relatives in California.

A statistical study of these forty-six patients in private employment and employed at the state hospital gives us a basis for evaluation of the project in terms of outcome and what it has meant to the patient.

Length of Time in the Hospital.—How long had these patients been in the hospital? Twenty-one had been in under

five years; twelve had been in from five to ten years; thirteen had been in over ten years; one man had been in twenty-two years. This is a different picture from that found in the usual parole to relatives. From a study made of parole to relatives, we found that the great percentage of those so paroled have been in under one year, and practically none have been in over three years. The longer the patient lives in the hospital, the less probable is parole to a relative.

Age of Patients.—Likewise, as a group these were middle-aged and elderly patients, especially those who went into private employment. Of the whole group only three were under thirty years of age; eleven were from thirty to thirty-nine years; eight were from forty to forty-nine years; twenty-four were over fifty years of age. Some of our best farm laborers were among these older men, ten of them being from sixty to sixty-nine years of age.

Diagnoses of Patients.—Dementia præcox and the manic psychoses were the most frequent diagnoses, there being thirteen in each group. At the state hospital there is a higher percentage of dementia præcox cases than of manics, and on the whole they are younger patients. Of the farm labors nine were classified as feebleminded. They have made good in a limited way; only one has been returned.

Present Status of Patients.—Of this group of forty-six people who earned $20,000, half of whom were over fifty years of age, none of whom were desired by relatives or friends, what can we conjecture for the future? Fourteen, or one-third, have now been discharged and are on their own; nineteen are within their first year of parole; three have had parole extended another year; two are deceased and ten [1] have been returned to the hospital. Even those returned are not considered a total loss.

Employment of Patients at the Hospital.—In the war emergency, we heartily endorse the employment of patients at the state hospital. While there have been problems of supervision, adjustment, and relationship with other attendants, we consider that these patients have made a valuable contribution to the hospital and to the war effort. Four of this

[1] One man was discharged and readmitted eighteen months later.

group were returned, but the other seventeen patients were given an opportunity that otherwise would have been denied them, and an experience that has been conducive to recovery.

To conclude, we believe that in the state hospitals of Iowa there are an undetermined number of forgotten people whose recovery would be hastened through family care and a well-directed program of employment. Before such a program can be launched, however, we need the leadership of an active mental-hygiene society that the general public may realize "that mental sufferers are patients to be cured, not mad men to be kept in cruel and hopeless confinement."

A WORKING-OUT PROGRAM FOR STATE-HOSPITAL PATIENTS

JEAN CAMPBELL

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FOR a number of years certain suitable patients from the Traverse City State Hospital have been allowed to earn money working outside the hospital. Prior to 1942, this work was, for the most part, confined to seasonal activities, such as cherry picking. The patients were generally taken out by hospital employees, and not more than fifteen or twenty patients were engaged during a season.

It was apparent from the first that the patients were definitely benefited by paid employment, but it was not until 1942 that the local demand for labor was great enough to provide jobs for any large number of them. The cherry harvest in that year was a bumper one, and it was evident that there would be a need for additional pickers. Various organizations, such as the chamber of commerce and the United States Employment Service, were advised of the availability of patients, and altogether some seventy-five persons, both men and women, were thus employed.[1] Since then, the hospital has been carrying on a relatively intensive work program, with approximately one hundred and sixty patients employed daily in the local community.

The work program is divided into two sections—the in-patient program for those living at the hospital and the paroled-patient program for those well enough to secure living quarters near the hospital.

Patients who live in the hospital are about equally divided between men and women. One hall has been set aside for the men and one for the women, and as homelike an atmosphere as possible is maintained. The two attendants in charge of these halls are highly skilled, and much credit is due them for the success of the program. Both halls are "open," with pleasant, well-equipped living rooms and easy access to the beautiful hospital grounds. Outside recreational facilities,

[1] See "A State Hospital as a Source of Man Power in the Present Emergency," by M. M. Nickels. MENTAL HYGIENE, Vol. 27, pp. 390–93, July, 1943.

such as shuffleboard, tennis courts, and croquet sets are available, and are used. Any summer evening, one can see a large number of these patients out enjoying healthful activities and companionships. So well do they adjust to this liberty that rarely, if ever, is there any infringement of the rules of behavior that would naturally have to be imposed in such a situation.

After the patient's doctor has given permission for employment, no difficulty is experienced in getting jobs, during this period of scarcity of labor. There are many more calls for help than it is possible to fill. These calls and the various other contacts with employers are cared for principally by the attendants in charge of the halls, although occasionally the patient's doctor or the parole social worker will be instrumental in securing some special work for a patient. Patients who may require occasional treatments, such as fever therapy or electro-shock, take work with the understanding that they may lay off for a half or a full day when necessary.

Although many of the patients work on farms or in domestic jobs, a majority are employed at local factories, restaurants, and stores. During one period of several weeks, as many as seven girls were clerking at a five-and-ten-cent store at one time. Some are able to do fairly skilled work at a defense factory. The patients go to work from the hospital and return after work. The patient's earnings are not paid directly to him, but are collected by the attendants and deposited to his account in the hospital accounting office.

Although quite frequently it is found that a patient does not do well in the job assigned and has to give it up, few difficulties with the mechanics of the program have been experienced. Elopements are practically nonexistent. Very occasionally there have been minor quarrels or disturbances at the place of employment, and the hospital has been called to come after the patient. Patients sometime break the rules by returning late to the hospital, taking a drink, or having a date. But such difficulties are decidedly the exception and at no time have they endangered the success of the program.

Besides the eighty patients employed on the day-by-day program, there is considerable additional employment during the cherry harvest, which is such an important occasion in

the Grand Traverse region. A much more deteriorated type of patient can go out with the cherry-picking crews—many of those who would not be capable of taking regular jobs. A variable number of patients go daily to the orchards. In 1944, as many as seventy were frequently employed in one day. They were picked up at the hospital by the farmers each morning and returned each night. A substantial lunch was put up by the hospital for them to take with them, and this was occasionally supplemented with coffee or iced tea by the orchardists. No supervision was provided by the hospital in the orchards. It meant a lot of extra work for the attendants in charge of employment, but there is always a festive, dramatic atmosphere about the occasion, and the pleasure and profit that the patient gains is good compensation.

The 1944 season was unusually long, extending from July 5 to August 10, the patients earning a total of $2,862.10. Six men earned over one hundred dollars apiece. Some patients earned only a few dollars, but it gave them an opportunity to make at least a little spending money for personal use.

There are bound to be troubles connected with this cherry-picking enterprise. In 1944, four patients eloped (all of them were returned within a few days); two patients broke their arms; several cases of poison ivy were reported; and a half-dozen patients had to be brought from the orchards because of abnormal behavior. But considering the aggregated employment over the whole period of 7,746 patient work days, this number of casualties does not seem high.

The other phase of the employment program deals with patients who are paroled to work locally. These are most frequently those whom the doctors wish to see fairly often, those who are only partially adjusted, and those who have no interested relatives or suitable home environment. About one-fourth of the eighty patients on this type of parole are women. These patients have usually been working and living in the hospital for a time before they are paroled. Their homes are not nearby, and they select their own living arrangements, some rooming and boarding, some rooming in hotels or private home and eating at restaurants, and some living at their places of employment. The age range is from seventeen years to sixty-eight, and the radius of

employment generally not farther than twenty miles from the hospital.

Wages have been discussed with the local United States Employment Service and, in general, the prevailing rates are paid. For about six months of the year, thirty or more men are regularly hired by farmers. Because of the variance in agricultural wages and to avoid exploitation of the patients, simple contracts are drawn up with the farmers, stating the amount the patients are to receive and specifying the hours to be worked. In these cases, the farmers advance the money needed for current expenses to the patients, but send the rest to the hospital to be deposited to their accounts. In all other cases, the patient is paid directly and manages his own finances entirely.

Besides farm and domestic jobs, a considerable number of patients are employed in restaurants and factories. At the present time, five hotels and restaurants and nine factories or businesses employ patients.

An article by O. E. Dorman, entitled "Jobs for Mental Patients," which appeared in the April, 1944, Survey *Mid-Monthly,* outlined the employment program in the Worcester State Hospital. There are many points of difference between this program and the one at the Traverse City State Hospital. Most of their patients presumably lived in their own homes and the program was carried out rather with a view to permanent industrial rehabilitation than as a temporary plan to aid in eventual normal adjustment. More intensive supervision was given their patients and the number in the program for the whole eighteen months was not so large as those on the employment program of paroled patients of the Traverse City State Hospital for any one single day. An analysis of diagnoses does show an interesting correlation:

	Worcester State Hospital (During 18 months period)	*Traverse City State Hospital* (On one day)
Dementia præcox	33	30
Manic-depressive	11	13
Psychopathic personality	7	6
Alcoholic psychosis	7	5
Psychoneurosis	6	2
Others	11	28
	75	84

In the Traverse City State Hospital, the twenty-eight patients listed under "Others" include eight additional diagnoses, which makes optimism possible as to an eventual adjustment for nearly any type of mental disorder.

This program has had its ups and downs. Patients have had to be returned to the hospital fairly frequently, but even when this happens, it is apparent that the work experience has helped in eventual adjustment. It might well be asked how much supervision can be given in this period of curtailed staffs, and it must honestly be acknowledged that there is not nearly enough. For over a year there was no regular parole worker. Since 1944, one worker has spent only part time on work parole. Fortunately, such a friendly feeling exists between all these patients and the hospital that the former usually can be depended upon to bring any major difficulty to some member of the hospital personnel. Much credit should be given to the sympathy, coöperation, and tolerance shown by the various employers.

It has been found that increased amounts of liberty can be given working patients without infringement of rules. Both groups go to shows, attend church functions, and shop, usually without direct supervision. With the first money earned, the men buy clothes and cigarettes; the women, clothes and cosmetics. War Bonds are a close runner-up.

And why is it worth while? Because the patients can earn some money and help out in time of labor shortage? Yes, but these advantages are of relatively minor importance. It is hard to describe the therapeutic gains, but they can be seen in the changed expressions on the faces of those who have worked for only a relatively short time. The tense, institutionalized, sometimes hopeless expression becomes one of vivacity and purpose. The grooming of these patients is dramatically better, their ability to find enjoyment in normal activities increases, their whole personalities seem to change, at least superficially; so that after a short period of work experience, the usual comment on a patient is, "You wouldn't know him. He has improved so."

Grace, a feebleminded girl, transferred from a state home for the mentally deficient as a "major behavior problem," got a job in a hotel washing dishes. She has worked at this

for over six months, and according to her own statement and that of her employer, is "being a good girl." Her face fairly shines with satisfaction over the successful performance of a paying, worth-while job which is within her ability. Mrs. Black, a manic-depressive, at one time extremely ill, is now in charge of a department in a relatively large store. Isaac, once a frowsy catatonic, so sick that he chewed the lapels of his coat, is now well-groomed and alert and has been working for nearly a year at a small manufacturing plant.

It is a well-known fact that militarists have found that quick catharsis and almost immediate return to the front lines is the best psychiatric treatment for war psychoses. There is an obvious correlation in this practice and in the rapid return of civilian patients to the stresses and strains of ordinary normal living. So remarkable and consistent have been the improvements in our experiment along this line that it would seem to indicate that the whole philosophy of occupational therapy may change. Actual outside placement for convalescent patients may be impossible when there is no labor shortage, but thought should be given to offering a realistic type of labor, perhaps in an industry created within the hospital, with some provision for compensation.

Work is not the only panacea for one mentally ill, but it has been demonstrated that:

> ". . . this toil becomes
> The solace of his woes,
> His sweet employ
> And surest guard
> Against disease and death . . ."

PSYCHIATRIC CASE-WORK AS A MILITARY SERVICE

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THE totality of our war effort has manifested itself in the utilization of every possible resource. Man power, one of the country's elemental resources, is the basis of all army activity. The purpose of this paper is to describe and to evaluate the part social case-work has played as a service to the army in making fuller use of its man power, to the end that the army's mission may be successful.

Case-work, as a term, is used here in the broad sense of a helping process for the individual soldier, the basic man-power unit. In the army, it most closely resembles what in civilian life is known as psychiatric social work. Here we will refer to it as military psychiatric social work, a term derived from the combination of skills—psychiatry and social work—in which its techniques originate.

Military psychiatric social work deals with some of the individual soldier's problems of personality adjustment. Since this involves emotional problems, it is a medical responsibility, and such problems in the army are the province of the medical officer or, as herein described, of the psychiatrist. Thus the case-worker who practices his profession in relation to a psychiatric responsibility is here known as the military psychiatric social worker.

The helping process or treatment, as described, will be differentiated from that carried on by the psychiatrist. It should be understood that ultimate responsibility rests with the psychiatrist in all decisions as to treatment and disposition, as determined by army policy and directives. The military psychiatric social worker, however, may at any one point carry responsibility for a large part of the helping process. This usually depends upon the nature of the soldier's problem, the proportion of military

psychiatric social workers and psychiatrists working together, or the length of the treatment contact as defined by the mission of the installation of which they are a part.

The setting in which the military psychiatric social worker works may be a reception center, a replacement or unit training center, a staging area, a port of embarkation, a combat-zone hospital, a reconditioning center, a redistribution center, or a convalescent hospital. The material and point of view of this paper are derived primarily from experience in a replacement training center and a neuropsychiatric reconditioning center. These two settings are associated with different stages of a soldier's army life—the first with its beginning and the second perhaps with the end of his activities as a combat soldier, after the rigors of field soldiering.

Since we are primarily concerned here with the generic case-work process, social work in the army is in many ways analogous to case-work in a civilian setting. Four factors stand out as common denominators in the practice of social case-work in the civilian community—the client, the community, the agency, and the social worker. In the army these most closely correspond to the following—the client to the "soldier-patient," the community to the army, the agency to the mental-hygiene unit [1] or an otherwise designated group to which social workers are assigned, and the social worker to the military psychiatric social worker or "263," as officially named under army specifications serial number.

It is clear that there are many differences between the average community and the army and considerable variation from one setting to another in the army. The military psychiatric social worker who works in a replacement training center must learn to understand and to work with the emotional reactions peculiar to that setting, and if transferred to a neuropsychiatric reconditioning center or other installation, he again must learn the conditions and purposes of his new setting. The generic elements remain the same, but they are focused differently. This is true of case-work in civilian life also. We have, for instance, the

[1] See "The Unique Structure and Function of the Mental-Hygiene Unit in the Army," by Major Harry L. Freedman, M.C. MENTAL HYGIENE, Vol. 27, pp. 608–53, October, 1943.

family case-worker and the child-placement worker. Even the most skilled family case-worker would have to learn the elements and emotional emphases involved in child placement before he could apply his skills effectively in that field. The prerequisites of the generic process would, however, remain the same. A similar transition period is necessary before the case-worker can become a military psychiatric social worker. All of the personnel from whose army experience this paper stems were well-trained civilian workers, some of whom had worked in clinical settings before they found themselves part of this new army community and agency and became soldiers working with soldier-patients.

In considering the development of military psychiatric social workers in the army, there is one important thing to recognize: all services in the army exist only to meet an army need; all effort is geared to this purpose. Thus, case-work as a military service came into being at a point where its value could be measured in terms of maximum effectiveness in man-power utilization. This has always been one of the main responsibilities of the psychiatrist whenever he makes dispositions that have to do with the duty status of soldiers. Herein the army, through its directives, maintains that personnel and emotional problems of adjustment require skilled handling by specialists. Soldiers with severe emotional problems are recognized as being ill. To carry out its mission, the army must be interested primarily in the interference with the performance of duty that any illness causes, since it is measured in numbers of precombat and combat casualties. Where such factors of interference can be removed or changed, the results represent both a saving and a maximum utilization of man power. From the army's standpoint, such a service is justifiable only if the results are concrete and measurable, quantitatively as well as qualitatively.

It was with the recognition of this fact as a focus that military psychiatric social work had its beginning in the army. One psychiatrist and one social worker, to whom others were later added, formed the army's first mental-hygiene unit.[1]

[1] See *One Hundred Years of American Psychiatry*. New York: The Columbia University Press, 1944. pp. 431–32.

Subsequently, the concept of a "clinical team," composed of psychiatrist, military psychiatric social worker, and clinical psychologist, was developed and later extended to the majority of replacement training centers in this country. The use of social workers became more widespread; and based upon their demonstrated value, formal recognition of the military psychiatric social worker was made on November 1, 1943, with the establishment of a Specification Serial No. "263." The experience of military psychiatric social workers was incorporated in the definition as follows:

"SOCIAL WORKER (0–27.01) 263

"Case Consultant	Medical Social Worker
Case Worker	Psychiatric Case Worker
Child Welfare Worker	Special Services Worker
Court Worker	Settlement Worker
Group Worker	Social Investigator

"Performs social case work with children or adults within such fields as public assistance, mental and physical health, services for handicapped, and community welfare.

"Interviews applicant for service and records case material. Investigates the environment of the applicant to obtain factual material, to determine which factors are responsible for the need for service, and to plan a course of treatment. On the basis of findings recommends definite action to be taken, administers financial assistance, offers guidance and consultant service in planning course of adjustment, or refers individuals to agencies offering specialized services. Interprets results of physical and mental examinations as they apply to the individual in the home, school, institution, community, or at work.

"May, if trained psychiatric social worker, work under the supervision of a psychiatrist to assist in the adjustment of emotionally maladjusted individuals by modifying their attitudes through re-education or by reducing or resolving the conflict by revealing the cause to the patient by direct or indirect treatment methods.

"May handle special cases usually difficult in nature or specialize in one phase of social case work.

"Should have at least 2 years of supervised experience in social case work activities in a private or public agency or have a graduate degree in social work from a recognized school of social work.

"Suggested Military Assignment:

"Group I. 263 Psychiatric Social Worker (AAF, AGD, MD)
275 Classification Specialist (Any arm or service)
289 Personnel Consultant Assistant (Any arm or service)
290 Personnel Technician (Any arm or service)"

It should be noted that an attempt has been made to maintain a minimum professional standard of qualifications. This had been found essential because of the great demands upon

the civilian social worker in his adaptation to this new setting. It is also seen, as previously stated, that the social worker functions in conjunction with the psychiatrist. The latter is the ultimate army authority for all decisions in regard to the disposition and treatment of emotional problems, since he is a medical officer. This makes the position of the case-worker under his supervision a strong one if based upon a good working relationship, born of an understanding of the rôle a military psychiatric social worker is capable of filling.

ANALYSIS OF THE ELEMENTS

In considering this specific adaptation of the generic case-work process, it is necessary to have some basic understanding of the individual and interrelated factors involved. Each of these—the army, the soldier, the mental-hygiene unit, and the military psychiatric social worker—is a topic whose complete exposition would require far more space than is here available. It is possible, however, even in a thumbnail presentation, to give some idea of each, so that an elementary grasp of the setting in which the social worker functions will be possible.

An army, in time of war, has one single motivating purpose—to impose its will upon the enemy. The mission of the army, therefore, becomes success in combat. To this end all procedures are primarily directed. Every arm or service and all contiguous forces of the country become either directly or indirectly subordinated to this purpose. Within the army structure, there can be no justification for other direct objectives because the people, through their government, have given the army this charge as its reason for being.

Coincident with this primary purpose, the army will touch every phase of the country's life, but the objective must remain clear, both within the structure and in relation to the country's philosophies and institutions. Therefore, within the army, administration becomes army administration, vocational education becomes meeting the army's needs for technical personnel, the medical profession becomes the army medical corps, and the social worker becomes the "G. I. 263."

The problems involved in an organization of almost incalculable magnitude and complexity are legion. These have been graphically and picturesquely described and illustrated in tonnage per man for supply, numbers of bars of soap transported for the African invasion, and quantity of amalgam used to fill the army's teeth. The experience of being a member of one company for one day in any part of the world would still be inadequate to give an idea of the gigantic undertaking of running an army, but it would engender some humble appreciation of the problems, multiplied a thousandfold, with which the army must deal. Add to this the fact that—*it moves!*

One of the keys to army administration is standardization. Where rapid change and constant movement, both in personnel and materiel, are the normal and expected, standardization becomes the stabilizer and constant. From a psychodynamic point of view, this cannot be overemphasized. It makes it possible for a soldier to enter an orderly room in Alaska, Burma, or New York and know that anywhere he hangs his barracks bags, he is at home in the army. Throughout, from the commander-in-chief down through the chain of command to the individual soldier, each job, each rank has its defined and clearly stated responsibility.

Within the stated limits of responsibility for a job for which the soldier or the unit of command is responsible, will be found the latitude and longitude of initiative, resourcefulness, and creativity. A soldier cannot argue the merits of when to dig a latrine, or why its dimensions should be what they are (the manufacturer of the cover, if it has one, might), but how it is done becomes his problem. Each individual is related to a unit, each unit is related to a larger segment of the organization, and all are interdependent. Upon the performance of each individual in the discharge of his delegated duty, the army is ultimately dependent. Hence the soldier's credo, "Do your job," because no matter what it is, some one is dependent upon its successful completion.

Thus, "chain of command" becomes many defined areas of responsibility, each complete within its limits and related to larger areas of responsibility. It is neither possible nor

is it always desirable that the individual know more than it is necessary for him to know in order to discharge his mission. If he is clearly identified with the army mission, he will not find it necessary, since he will clearly understand his defined responsibility. He is informed of his job through "directives," promulgated by the commander-in-chief through lines of administration commonly referred to as military channels.

In this way individuals are aware of what they are being made responsible for, and have the means of delegating and transmitting other partialized responsibilities. A regimental commander, charged with holding a sector, in this manner delegates to his battalion commanders the holding of various areas thereof; or the commanding officer of a replacement training center informs his plans-and-training officer that a school will be required to produce five hundred radio operators at a given date. How this partialized job is completed becomes the responsibility of each subordinate unit commander.

It is obvious that the problems attendant upon such organization defy description. The personnel running into well-advertised millions, the differing vocations in thousands, the constant limits of time and pressures beyond one's immediate job, all enter into the picture. In the early developmental stages of the present army, it was necessary to train and school soldiers and officers in incredibly brief periods of time. It became necessary to teach skilled vocations almost simultaneously. The army's needs in the fulfillment of its mission were an almost bottomless pit into which the physical stamina, the emotional balance, and the intellectual capacities of each inductee were plunged.

Each hospitalization, each AWOL, means that a soldier may lose weeks of physical training and classroom instruction. Any personal problem that a soldier has that interferes with the performance of his duty multiplies and becomes a negative factor in the successful completion of the army's job to impose its will upon the enemy. A negligent K.P. may easily cause the hospitalization of an entire company or squadron. In the higher echelons—such as staging areas, ports of embarkations, and theaters of operation—the prob-

lems of the individual that interfere with the efficient performance of his duties are measured in terms of available truck drivers, D.A.R. men, wire linesmen, and the like. It, therefore, becomes a vital concern of the army when any soldier has a problem that impairs his efficiency as a soldier or that affects adversely the efficiency of other soldiers with whom he comes into contact.

In civilian life, a man in our culture grows up within his family group in a community in which there are multiple self-determinations and choices. The inevitable question of the adult to the adolescent is, "What are you going to be when you grow up?" The individual is a member of a family and his place is assured. No one can replace him, nor can his identity become confused, though he may "look like" some one else or be "almost like my own son." His place is exactly like no one else's, no matter what the resemblance may be. Allowances may be made for him, his wants may be anticipated, help may be offered in crises, and in general he has many supportive elements on which to lean. If he does not feel well, he stays home from work or school; if he has a hangover, he takes it easy; or if he cannot keep an appointment or does not wish to, he offers an apology.

After taking the oath of a soldier, however, his problem is focused on just one responsibility—to be the best soldier he can. His own choices become limited almost to, "Will I be a good soldier or won't I?" His drives must be realigned to this end, for if he does not meet the standards of army performance, he then has no latitude within which to make further choices. Meeting the army on its terms becomes the first great hurdle for the civilian in the transitional stage. This is usually accomplished during the basic training stage, when the civilian begins to learn what he now is before he can be anything else—a soldier.

Being a soldier is not a part-time job, a vocation, or an avocation. It becomes—whether for the duration, plus, or as a career of choice—a way of living to which everything in a man's life must subordinate itself. A soldier can do nothing unless the army says he can. This inevitably creates problems, especially for the soldier in our culture. Frequently army requirements must conflict with individual

ambitions, interests, and previous commitments. If there is an abundance of lawyers, the army may train them as infantrymen if they are allotted to the ground forces, or as navigators if they are assigned for training in the air forces. If a soldier is concerned about his wife's health or financial condition, he can do nothing about it unless the army grants a furlough. If the army has other requirements, the personal problem takes second place and the residual complications become the soldier's concern.

He lives in a barracks, where his habits of personal hygiene affect the life of the man next to him, or where his own mental and physical health affects the entire group, and vice versa. He gets up when the group arises and makes formations, whether he likes to or not. A first sergeant has to produce a company and not a set of excuses or apologies, most of which he has himself tried to use at one time or another. Even a mild indisposition becomes a medical question for which the medical corps has responsibility, and if examination and treatment reveal nothing that requires hospitalization or return to quarters, the soldier will do duty in the condition in which he finds himself. He cannot choose to remain in the barracks or away from formation without creating a further problem for himself with the army.

He is under constant pressure to meet the demands of the army, to absorb physical training and instruction, to develop skills that the army needs, and to coördinate his training and experience with those of other soldiers in his unit. There is always the unknown and unknowable next move, next installation, next activity. If he adapts well, he accepts the constancy and stability of his barracks bags—if they are not lost—or derives strength from the men in his outfit who are sharing his uncertainty. The least common denominator of the G.I. latrinograms and the gossip sprinkled with comparisons of other installations and experiences is always a common ground upon which soldiers can meet and feel "at home" with one another. In this a great fraternity of feeling can develop a stability and generate a force to counteract the chronic uncertainty that is normal to the soldier's everyday existence.

The civilian supports having been removed, the adjust-

ment having taken place, and the elementary stages of learning to walk, talk, dress all over again having been passed, the demands on the individual increase. He learns a skill, if he is capable and is given the opportunity. He moves from camp to camp, is joined to a unit or is not, and goes through staging and shipment into combat areas. In each phase there are different problems created by the demands peculiar to the stage in the human conveyor system at which the soldier finds himself. The pressure mounts in anticipation of combat and then in a baptism of fire. The cycle can be expected to tax to the utmost the resources of the most durable and balanced personality. The chronic anxiety and threat of mutilation (frequently more feared than death) aggravate the concern any soldier may have about his capacity to meet the reality he is expected to face.

In the initial separation stages, the problems are readily seen in chronic sick callers, in AWOLs, in questions about classifications, in insubordination or other behavior symptoms.[1] Internalized, the problems are apparent in insomnia, poor appetite, loss of weight, homesickness. There is "griping," comparisons of the present situation with the life led when a civilian.

It is when these problems come to the attention of the army through the soldier's inability or unwillingness to perform assigned duty that the army assumes responsibility for them. If a soldier can carry his problem and perform effectively, then it remains his personal affair.

In combat, fear and anxiety are a sustaining and protective force until they reach proportions beyond which the individual cannot carry them. At the point of neuropsychiatric breakdown, the military psychiatrist may use his professional skill to return the soldier to combat if, in his professional judgment, this is feasible within his techniques. If this is not possible, the soldier is removed from his unit and returned to the Zone of the Interior.

This creates further problems for him. He has lost one of the most sustaining forces available to him—"my outfit." His problem, once he is removed from combat, becomes that

[1] See "Mental Hygiene First Aid for Precombat Casualties," by Major Harry L. Freedman, M.C. MENTAL HYGIENE, Vol. 28, pp. 186–213, April, 1944.

of not having fulfilled his responsibility to his unit. He relives his combat experiences, keenly feels the loss of comrades, but above all becomes a soldier-patient and a casualty, usually without demonstrable wound. He has difficulty in equating his own combat experiences, and those of the men whom he has left to "sweat it out," with the problems and attitudes he encounters in the Zone of the Interior. He has difficulty in his relationships with the noncombatant soldier, the civilian, or his officers.

This soldier becomes a responsibility of the army in so far as concerns his reconditioning for further military service or his separation for prolonged treatment by agencies with that responsibility. Treatment within the army structure for return to a limited assignment brings with it, for the neuropsychiatric casualty, return to the status of a useful soldier. This not only is an asset to the army, but is also of immeasurable therapeutic value to the soldier.

In this connection a brief mention should be made of the problems arising out of assignments overseas, or within the continental limits of the United States, that in their monotony and routine offer a fertile field for frustration, with little comfort in the knowledge that the job, though without stimulation or measurable results, is none the less an integral factor in the completion of the army's mission.

This, then, is the panoramic background to which the psychiatric social worker in the army must relate if he is to contribute his professional training and skill to furthering the mission of the army. He begins like any other civilian—a podiatrist, a pharmacist, or an entomologist. He learns how to make a bed, to roll a pack, and to shoot a rifle. He lives in tents or barracks, uses a washroom with six or twelve sinks to fifty or a hundred men, and wonders what is going to be asked of him next. Prior to the present war-department directives for his assignment, he might have been trained in a specialty in which his professional training would be used indirectly, or else in some skill for which he showed potential ability and which the army needed.

The military psychiatric social worker is a soldier first and incidentally a social worker, if assigned as such. To-morrow, if the army's need changes, he will be utilized

in another capacity. His acceptance of this fact is essential if he is to perform his assignment with maximum effectiveness. The only way in which a social worker can function within the army structure is by directive which relates him to a unit in the chain of command. The army issues such directive only when delineating a responsibility that has a relation to its mission. Therefore, when a social worker becomes a soldier and is assigned to a unit that has need for his professional skill, he assumes the duty of a soldier and a member of the unit in carrying out the directive.

This kind of orientation may be difficult for the civilian social worker to accept. The many shades of professional philosophy and differences in technical training may be reflected in differences in the ability of civilian social workers to reconcile the concept of helping the individual with his problems and that of the military psychiatric social worker charged with helping the soldier become more effective as a fighting man. In order to function in this way, there is need for an unequivocal belief in the purpose of our army. This conviction—supported by the training of a professional school of social work whose philosophy of social work is that of helping people meet the demands of reality—is essential to the development of the military psychitric social worker.

Military social workers who have had experience in large school systems, or in public welfare or other governmental agencies, will at once be aware of the need to understand the scope and limitations of their unit's function as defined by directive (which corresponds to the civilian legislation that establishes an agency) and the lines of administration (in this case army channels) through which it operates. Translated into terms of army administration, this involves a thorough understanding of the mission of the particular installation in which the unit is to work and of the different components within the installation with which the unit will be related. It presupposes an ability to perceive the multiple responsibilities of the commanding officer, the responsibilities that have been delegated to the various staff sections, and the unit's relation to each and several. Only in this way can the social worker be of service to the command.

With knowledge of the mission of the installation to which he has been assigned and understanding of the administrative ties that permit him to use his skill, the social worker must be prepared to deal with another factor—that of the soldier in relation to the particular setting. This calls for as deep an understanding of personality interaction as one can muster. It presupposes a sensitivity to symptomatic behavior and the dynamics involved therein. It calls for a careful appraisal of what a reaction to the reality might normally be and when feeling is out of proportion to reality pressures.

It is in this area that the social worker's responsibility to the military psychiatrist should be clearly understood. The psychiatrist is ultimately charged by the army with responsibility for the mental health of the soldier, and the military psychiatric social worker derives his function from a direct working relationship with psychiatry.

Supervision within the army structure begins at the point at which the civilian social worker who has become a soldier finds himself in his professional training and development. In the matter of previous training, army social workers range from those who have, through various in-service experiences and training, rendered a specific agency service, to those who have been professionally trained in a philosophy of social work and who have had wide agency experience. The primary responsibility of the supervisor becomes that of helping the military psychiatric social worker translate into practice the function of the specific unit to which he is assigned. This involves a knowledge of the mission of the installation, of the resources within it, and of the manner in which the social worker meets the soldier's problems of army adjustment. It requires a sensitivity to the army's needs, to the soldier's personality, and to the possibilities of dealing with both.

The core of the matter is that whatever the resolution of the soldier's problem may be, both he and the army benefit through the opportunity given to the soldier, within the interview setting, of coming face to face with the army in a consideration of his problem. This factor of creating a situation in which the army makes it possible for a soldier to discuss his problem is the central point around which the

dynamics of case-work treatment revolve. The paradox has a positive shock value.

This does not mean that the army, through the military psychiatric social worker, has a solution for all the manifold and complex problems that affect the military efficiency of a soldier. The army does, however, provide a number of resources, and coöperates with other agencies interested in serving the individual soldier who is having difficulty while maintaining a duty status or during the separation process. These resources, which develop as the need for them is demonstrated, are found in the company commander, the training centers, the personnel sections, the personal-affairs officers, the special-service officers, the classification officers, the army emergency relief, and the army-forces institute, as well as such quasi-military and public agencies as Selective Service boards, the United States Employment Services, and so on.

Knowledge of these resources, as they relate to the particular installation in which he is serving, becomes the reservoir that the social worker carefully and selectively uses with the client as he is able to use them in terms of his problem. In his official capacity and line of administration, the social worker has access to channels through which these resources are made available to the soldier. He is then discharging the army's responsibility for meeting the individual soldier's needs, and he may use several of these resources before completion of the case.

The particular contribution of the social worker's services is the product of the case-work treatment process which will be discussed in this paper. Perhaps the most important element in this process, and the most difficult to evaluate, is the service of counseling. In an organization in which authority is the staff of responsibility, the soldier who has a problem suddenly finds the army giving him help with it and requiring him to take some part in its solution. Where before he may have had no opportunity to "gripe" except in barracks, now he has a chance to air his feelings and to evaluate them in the light of counter-pressures and alternative possibilities.

He may find that while his living conditions or training assignment or combat experiences have not changed, his

attitude toward them has changed and made them more tolerable or even desirable. He is talking to a soldier in uniform who understands his problem, and this fact becomes the catalytic agent in the working relationship that is so vital in the process. The soldier has an opportunity to explain why he went AWOL, why he wants a transfer, how he has been unable to get a pass or a furlough, how he has been "pushed around," and any of the countless problems that render him less efficient than he otherwise might be.

It is the responsibility of the military psychiatric social worker to give the soldier the army's attitude in relation to his problem, so that he will be aware of the reality to which he is expected to adjust. Out of the process the soldier gets the opportunity to crystallize his problem and to equate it with the resources and attitudes of the army, making choices in his next step of adjustment or maladjustment. This involves participation on the part of the soldier and a commensurate responsibility for his decisions.

The psychodynamic factors at work in this service are many and call for the highest degree of technical skill. The process offers a basis on which the soldier may be required to make a decision that cuts very deeply into the pattern of his adjustment, or one in which his intellectual understanding and his emotional development are not on the same plane. Frequently the soldier does not want a solution of the problem that his being in the army has created for him. Counseling here involves the same basic factors—the army, the soldier, and the social worker—but the focus of the helping process becomes the army's requirement of change in the soldier, and the question whether or not the soldier is able to find equity in such change.

Counseling is the service of the military social worker that derives solely from his own professional techniques and that is present in every service rendered by him. When it is the sole service rendered, the soldier has an opportunity to develop a clearer understanding of his problem, to see the army's attitudes in relation to it, to evaluate the possibilities of its total or partial solution, and to acquire further experience of what it means to be a soldier.

The ability of the soldier to profit from the service of

counseling does not depend only upon his being able to render useful military service. Throughout the interview, the military psychiatric social worker assumes the responsibility of evaluating the soldier's military suitability or potentiality. The social worker's relationship to the psychiatrist fixes this responsibility. As the soldier is able to relate to the social worker and to assume a participating rôle in the solution of his problem, there is real evidence of his personality strengths and weaknesses. As he is able to tolerate the frustrations and competitiveness of army life, one can see him meeting future problems. In the unfolding of his abilities to meet situations as a civilian lies the knowledge of whether or not the present situation is a repetition of a chronic, long-existing pattern of behavior, or is a reaction to the immediate demands of army life. In gathering and presenting this material to the psychiatrist, the military psychiatric social worker performs an invaluable diagnostic function.

In many installations, a mental-hygiene unit may be called upon for an opinion on, or a personality evaluation of, an individual. A courts-martial board may have a question as to a man's mental competency; a company commander may want an evaluation of an individual's capacity before making a recommendation; the adjutant, the intelligence officer, or the inspector's office may require a personality evaluation before proceeding in a matter pertaining to the function of their offices.

In the process of securing material that will help the psychiatrist in his rendering of an opinion, the soldier may derive a good deal of benefit from skillful interviewing, since the discussion will inevitably have a bearing on the immediate situation. As a result of a discussion of the soldier's problem, he and the worker may agree that his army adjustment might be improved through the working out of an assignment in which he feels capable of functioning, and in which the social worker considers that he would meet the army's requirements and could be of most useful service.

In the training or redistribution center, this may result in the soldier's transfer or reassignment. He may be declared ineligible for overseas duty; or he may be returned to duty,

with special consideration of limitations, either mental or physical, for which war-department directives have made provision and for which the unit wherein the social worker performs his duty has an administrative responsibility. In reconditioning facilities and other installations, the medical corps is charged with carefully evaluating a soldier's limitations and making them a matter of record, so that assignment by the unit commander may be intelligently accomplished with these limitations in mind. A discussion with the soldier of his potentialities and limitations, and of the army's recognition of them, becomes a further therapeutic experience for him and offers him an opportunity to participate in the planning for his continued service. Here, again, the social worker has knowledge of army policy and eligibility requirements against which the soldier can weigh his own capabilities.

The end result of the relationship between the soldier and the military psychiatric social worker is a concrete decision in which the soldier always knows where he stands. This decision, in terms of the army, is a disposition which is the final responsibility of the psychiatrist, an army medical officer. Disposition may involve a return to a duty status with recommendation of special consideration in assignment, transfer in training assignment, hospitalization, recommendation to an appropriate board of officers for discharge via pertinent army regulations, recommendation of return to the Zone of the Interior, or some other measure, depending upon the mission of the particular installation in which the unit functions.

The settings in which the military psychiatric social worker may operate are as varied as those of the psychiatrist to whom he may be assigned. He may find himself in a general hospital, a port of embarkation, a division, a training center, a redistribution center, or a number of other installations. He may work with a psychiatrist alone or as one of several other social workers. He may "carry" a case from a few days to usually not more than two or three months. He may see anywhere from three to eighty-nine soldiers in one day, and an interview may vary from ten minutes to an hour and a half. He always has a concurrent responsibility for

other military tasks which may include duty as latrine or barracks orderly, charge of quarters, bivouac, maneuvers, or other duties, as may be required. He is always a soldier. He always knows why he is seeing a man and, therefore, has direction to his interviews as well as a clear view of the extent and focus of his contact with the man.

THE RÔLE OF THE MILITARY PSYCHIATRIC SOCIAL WORKER IN TREATMENT

The Administrative Setting.—The case-worker's real strength in the performance of his job stems from the nature of the administrative setting in which he operates. Experience has shown that the mental-hygiene unit or "agency" can render its service most effectively when it is directly related and responsible to the command of the installation with which it is connected.[1] The channels of authority and action in a military installation are manifold and each exists to carry out a specific part of the total mission. The mental-hygiene unit, in serving an installation, should be related to all sections and should meet the needs of all personnel as required. For this reason its line of authority should be directly to the commanding officer of the installation. At the same time the unit must have a flexible liaison with the other sections in order to communicate freely with them. It is also necessary that the function of the mental-hygiene unit be stated clearly and that it be fully interpreted to all concerned. The mission of the unit is best formulated when it is made synonymous with the interests of the command. When thus supported, the mental-hygiene unit can attain its most effective level of performance.

The Case-Work Treatment Process.—The helping process in the army may originate in several different ways, depending mainly upon the nature of the installation to which it is a service. One can also speak of an intake process or method of referring cases. Where the installation, such as a replacement training center, exists for the purpose of training the average soldier, the army is chiefly interested in the individual soldier's progress or lack of it. A soldier's

[1] See *Manual of Military Neuropsychiatry.* Philadelphia: W. B. Saunders and Company, 1944. Topic 34.

inability to keep in step with the requirements of his training schedule is due either to physical or to emotional causes. If he is ill or suffering from a physical disability, his problem clearly is one of medical treatment and disposition. If his problem is in the area of personality adjustment, he may come to the attention of the psychiatrist, usually at the request of his company commander or through his instructors.

Where an agency or mental-hygiene unit exists in such an installation, and its services are known to all whom such problems may affect, the soldier is usually referred to it for evaluation, treatment, and disposition. Since the mental-hygiene unit is a service to the command, the officer in charge refers the soldier to the unit directly through channels. This is a direct method of referring.

In some cases, the unit may represent a source of help to the soldier, and he may decide to refer himself. It is important, however, that such a reference go through his commanding officer. The official nature of the reference is an important dynamic factor at the beginning of the helping process. It gives the army a responsibility and the soldier a sense of security in knowing that his problem is also the army's problem. Frequently, a soldier who, for emotional reasons, is having difficulty in meeting the requirements of training tends to consider his problem apart from the fact that it stems from his being in the army. This creates a difficulty for the case-worker in that it is hard to find a point of approach when the soldier sees his problem only in relation to himself. A case history will illustrate this more clearly.

> A soldier assigned to radio operators' school had heard of the mental-hygiene unit and came in of his own accord to request the unit to help him obtain an emergency furlough. He gave no reason at first, but simply impressed upon the intake worker the fact that he was sure the unit could help, that the matter was urgent, and that unless such a furlough was at once expedited, he would go AWOL.
>
> The worker explained the position of the unit in not being able to help him, since all furlough requests had to be initiated through the commanding officer. If the soldier had a legitimate reason for his request, and if it was an emergency that would warrant time off from his scheduled training, then he would not need any one to intercede for him.
>
> At this point the soldier gave the reason for his request. His fiancée had exercised much pressure upon him to get married on the following

week-end. She had made plans to that effect, and told him that unless he got the furlough, her patience with him would be at an end.

The worker did not get into a lengthy discussion of this material, but again told the soldier that the only basis on which the unit could help him would be if he requested reference to it through his commanding officer.

The soldier then went to his C.O., who denied him the furlough on the ground that his training schedule required his presence, but who did refer him to the unit for discussion of his problem. On returning to the worker, by appointment, the soldier was prepared for a full discussion of his problem. Much of his outward anxiety had disappeared. It came out that he was on the verge of failing in his studies, and that the pressure from his fiancée was becoming unbearable. He was torn between what the army expected of him, and the claims upon him of his recent life as a civilian from which he had not yet detached himself.

The fact that his C.O. now had given official recognition to his problem gave both soldier and worker an army-rooted basis for taking it up. The soldier saw that the army, in a sense, by tying him to his training schedule, had precipitated part of the problem. At the same time he was able to talk about his own doubts as to whether or not he should get married while in the service. He was ambivalent about it, and had not had the courage to discuss his feeling with his fiancée. This he saw as necessary for his own peace of mind, and he finally decided to write to her and try to give her some understanding of the whole situation. After a brief week-end visit with her, he felt much relieved. He said that the whole difficulty had arisen from his fiancée's lack of understanding of what it would mean to her, too, for him to be in the army for an indefinite period. They did decide that at the end of his training period they would get married, and that he would submit a request for a furlough at that time.

The soldier was seen again in two brief contacts. His work improved, he seemed much more settled, and finally after qualifying as a radio operator, he got his furlough and was married.

This case illustrates many of the normal problems a new soldier may face, but here it is cited to show how the reference or intake process itself was used to serve the soldier. It helped him to focus his problem, to understand its relation to the army, and to mobilize himself to take steps that resulted in its solution. It was, in fact, a service both to the soldier and to the army—to the latter in the fact that the soldier became a qualified radio operator instead of going AWOL and losing time that he would have been unable to make up.

The function of the unit is to help the army or the officer in charge with the problems encountered in men assigned for training. This may seem to imply a lack of consideration for the soldier. But if a soldier presents a problem to

the army, then it is certain that the soldier also has a problem. The two are inevitably related and interdependent. If the army is helped, then the soldier also is helped. It bears repetition that the service of the unit is for the army first. If the soldier gets help from a decision made about him by the army, then this is desirable; or if the army can gain from help given to the soldier, this, too, is a positive good. As a matter of fact, the only way in which a soldier can be helped is in a way that benefits the army. The army does not treat for the sake of treatment alone; there would be no more valid reason for it to do so than to undertake to continue the education of soldiers without relation to army needs.

Since this discussion of the case-work process will be constantly concerned with the defined function of the mental-hygiene unit from which it operates, a definition of such a unit's services may be illuminating:

> "1. The mission of the Mental-Hygiene Unit is to:
>
> "a. Provide Mental Hygiene facilities to ..... organizations and officers and to assist them with soldiers who present various forms of maladjustment, as inaptitude, unusual behavior, malingering ("goldbricking"), recalcitrance, alcoholism and others.
>
> "b. Institute such corrective measures as are considered appropriate by the Director thereof, to reduce or eliminate the individual's maladjustment and eradicate factors related to incipient causes of mental breakdown to the extent necessary for the soldier to perform military duties.
>
> "c. Determine whether an individual whose case is brought to it for attention is either in an assignment that does not utilize his capacities to the fullest possible extent or is being trained in a skill beyond his capacity.
>
> "d. Recommend for discharge from the Service such men who, because of mental or emotional factors, cannot function adequately or who present a hazard to the other men.
>
> "e. Provide psychiatric, psychological and social data and make recommendation to Courts Martial and discharge boards.
>
> "f. Aid soldiers who are discharged from the Service to make the transition back to civilian life.
>
> "2. Soldiers in the ..... in whose cases action by the Mental Hygiene Unit appears necessary will be referred thereto by any one of the following:
>
> a. Staff Sections
> b. Personnel and Classification Officers
> c. School Directors
> d. Chaplains
> e. Regimental, Battalion or Company Commanders
> f. Infirmaries and Hospital

g. Inspector and Intelligence Officer
h. American Red Cross.

"3. Soldiers desiring to consult the Mental Hygiene Unit are to be referred thereto upon request by their company commander.

"4. *Immediately* upon return to duty, an enlisted man who has been AWOL for more than 24 hours will be reported to the Unit by memorandum, noting the soldier's name, serial number, date of leaving and return and any other pertinent information.

"5. In all cases where Courts-Martial charges are filed, the soldier in question will be referred to the Unit *without delay.*

"6. Immediately upon approval by appropriate boards of the discharge of any soldier, his name will be brought to the attention of the Director.

"7. In addition to the types of cases referred to in earlier paragraphs, there will be brought to the attention of the Director of the Unit those men showing indications of illiteracy or mental deficiency, either at time of arrival (as indicated by low Army scores, behavior during initial classification interview, etc.) or during subsequent training period.

"8. A limited service board, with the Director as president, having been established for the ....., the limited service status on all soldiers arriving here so classified will be brought to the attention of the Director for review and evaluation of assignment or reclassification. All general service ..... soldiers thought to be eligible for limited service status will be brought to the attention of the Director for evaluation, assignment or reclassification.

"9. The method of referral shall be through written memoranda giving reason for referral and other relevant information. On receipt of such memoranda, the Unit will schedule appointments and call in the men concerned. Where expediency is indicated telephone referrals may be made.

"10. The Director of the Unit will dispose of the cases referred to him by any one or a combination of the following methods:

a. Counseling, psychiatric social work and psychological testing.
b. Reclassification, where considered advisable.
c. Special programs coöperatively developed through contact with the sources mentioned in paragraph 5, above.
d. Special psychiatric treatment.

"In these categories (a to d inclusive) are included reclassification of all actual or potential school failures due to demonstrated inaptitude, extreme dissatisfaction or psychological hazards.

e. Referral for training to the Special Educational Unit.
f. Extension of training time where such time, lost because of factors beyond the soldier's control, is necessary to complete training.
g. Referral to American Red Cross.
h. Psychiatric observation to Station Hospital.
i. Recommendation of discharge because of disability. (Within this category are soldiers found to be psychotics, psychoneurotics, epileptics, etc.)
j. Recommendation of disposition by a board of officers convened under Section VIII, AR 615–360. (Within this category are soldiers found to be psychopathic individuals, mental defectives, chronic alcoholics, enuretics, drug addicts, etc.)

"11. Cases scheduled for action by boards of officers convened under

> the provisions of Section II and Section VIII, AR 615–360, will be handled as provided for by pertinent regulations.
>
> "12. Reclassifications will be put into effect by the Personnel Officer through training assignment memoranda.
>
> "By command of Brigadier General ....."

Since each officer in charge of enlisted personnel has a copy of this through command distribution and is given adequate interpretation of its use and purpose, a degree of uniformity of understanding is achieved. The officer can thus be assured that there are ways in which the army is prepared to meet his problems. He is thereby often relieved of a subtle feeling that he is responsible for all problems. He can, instead, refer men whose emotional difficulties interfere with their work to an official source for help and disposition. This enables him to secure special help for those individuals who require it, instead of consuming time in trying to solve problems of personality with which he is not equipped to deal, perhaps at the expense of the welfare of an entire company.

Another form of intake or reference exists where an entire installation has been devoted to the treatment and disposition of certain types of case. Reference here is based upon an army policy which directs that a particular installation be set up to deal with specific problems. Since we are dealing here with case-work in relation to psychiatry, we have in mind such installations as neuropsychiatric sections of station and general hospitals, neuropsychiatric reconditioning centers, and neuropsychiatric convalescent hospitals, whose chief concern is with the emotionally disturbed soldier.

An important psychological factor operating here, both for soldier and for military psychiatric social worker, is the fact that the army has recognized the existence of an emotional problem that interferes with duty and has also assumed responsibility for its handling. In most cases, a soldier who has suffered a "nervous breakdown" has already been in several hospitals. He is fairly well aware of his problems in the sense that he often realizes that there is a difference between a mental or emotional problem and a physical one. His real understanding of the relationship between somatic complaints and emotional determinants is usually very much confused. His transfer to a hospital or unit where there

is a clinical team may originally have been based upon a quick psychiatric examination at the scene of breakdown. Disposition rather than treatment is usually indicated here, because of the many external pressures.

The experience upon which this paper is based is limited to the neuropsychiatric reconditioning center or convalescent hospital, which almost always has been preceded by other consecutive hospitalizations in the chain of command to the Zone of the Interior. The most effective beginning in this setting has been found to be a so-called "orientation." Depending upon the specific functions and differences among such installations, the orientation may proceed along the following basic lines:

Individually, or in a group, the soldier is told that the purpose of this new installation is to help him get as well as possible. It is recognized that he has been in various hospitals before coming here (most soldiers have a marked resentment and a feeling of having been "pushed around"); and he is given to understand that during his stay at the installation (the length of time may be from four to eight weeks), a decision about him will be reached; that he will not be sent to another hospital unless he is seriously ill; that he may be able to return to duty, or he may be discharged. It is explained that he will see the psychiatrist and a social worker, who will study his charts and records carefully and give him an opportunity to discuss his problems fully. In all cases a medical officer sees the new patient on admission. Orientation may be given either by the psychiatrist or by the military psychiatric social worker, depending upon circumstances.

One of the chief differences between the hospital setting and an installation whose purpose is rehabilitation or convalescence is the fact that in the latter the soldier is out of the bathrobe-and-hospital atmosphere and is back in barracks. His patient status is maintained through constant medical supervision, but the atmosphere and program are quite different from those of a hospital. Experience has shown that most soldiers long hospitalized have an urge to "try the outside," and herein lies one of the most important therapeutic dynamics for the military psychiatric social

worker. Frequently, during the orientation period the soldier is much relieved when he learns that he will not have to wear a hospital robe.

While the soldier is given as much reassurance as is realistically possible, he is also told that he has a share of the responsibility for getting well—that while he may be finding the army a problem, the army also has a problem in its responsibility for helping him. It is pointed out to him that he should not expect any sudden cure—that, as a matter of fact, he may have his kind of nervousness for a long time, but that this does not necessarily mean that he will be a total invalid in terms of future usefulness to himself or perhaps to the army. This is the army recognizing the fact that the man is ill, but is still a soldier. This implies mutual responsibilities.

Finally the soldier is given an army survey of the installation's program for him. In one installation, a convalescent hospital for neuropsychiatric casualties, the following written orientation material is given to supplement the foregoing discussion:

> "This is a hospital.
>
> "It may already have struck you that it is different. So different that it doesn't seem like a hospital. It has been planned that way.
>
> "We want you to be happy, to enjoy yourself while you are here. We also hope that we will be able to help you. So while we emphasize recreation and hobby activities, we also include activities in your program which we believe will be useful in getting you back into better condition.
>
> "During the first day or two you will have contact with the doctor and various other people with whom you will have an opportunity to talk over your situation, your hopes, your problems.
>
> "You will always be informed in advance about the program of activities for the day.
>
> "You will be living in barracks with other men. Assigned to each barracks are counselors[1] who will be glad to answer any questions or discuss with you any difficulties which you might have.
>
> "(Sick Call will be held each morning at the dispensary building #..... at 0745.)
>
> "The program which you will follow will be made up according to your interests and needs. Your own program will be worked out carefully with you so that you can have a say in what you will be doing.

[1] The term counselor is used for its more popular connotation, although the soldier tends to refer to the military psychiatric social worker as "my case-worker" and to the psychiatrist as "my doctor."

"Some of the sports available are handball, badminton, boxing, baseball, volley ball, football, etc. There will also be supervised job-hobby activities, such as auto mechanics, arts and crafts, woodworking, photography, etc.

"During every evening in the week special programs will be planned such as USO dances, Red Cross dances and parties, special entertainment brought in from outside, latest movies which are shown in WD theatres.

"There is a PX, a service club, a gymnasium, library, and post tailor all located conveniently.

"Passes and furloughs will be given liberally on a basis of good attitude and effort. Remember passes and furloughs are privileges. They logically follow commendable effort.

"Keep your quarters clean. Keep yourself looking neat. Being presentable is important in the army just as it is in civilian life.

"Follow the customary rules and regulations of military discipline and courtesy. If you have any questions, see your counselor first. He will get the information for you or refer you to the proper service."

Questions raised by soldiers about this orientation are answered as fully as possible on a general basis. When orientation takes place in groups, it has been found best to refer individual needs, unless emergent, to the case-worker or psychiatrist, with whom the soldier will have a regular appointment in a day or two. In addition to its therapeutic value, this form of orientation provides diagnostic information. The trained military psychiatric social worker is quick to sense those who will have difficulty or whose symptoms are severe. They are at once referred to the psychiatrist for disposition.

The Continuing Process.—In the continuing process, many generic factors can be found that will be the same in whatever type of installation the military psychiatric social worker may find himself. There are also many variations, depending upon the setting, the mission of the installation, the relationship of the social worker to the psychiatrist or the psychologist and so on, so that a well-rounded description of "case-work in the army" is not possible in the space available. We have already seen two different beginnings. There are others, and initiation of the so-called continuing process will be influenced by many external factors, some positive and others negative. One of the most certain problems will be that of limited time—the necessity of streamlining decisions and cutting paper work down to a minimum. The worker will want to know the nature of the problem as presented by a soldier referred to him. He may or may

not get a clear statement from the referring source. If his unit has a clear reference policy, then he should have a clear idea of what the army attitude is in relation to the soldier's problem.

The military psychiatric social worker in an installation with a specific and defined treatment mission will be much farther ahead, since he can read clinical charts, and so on, even before he sees his patient. Let us follow him through a typical case, with an analysis of the process. This case illustrates some of the dynamics that operate in a replacement training center.

> A soldier has been AWOL for ten days, and is referred to the unit by his commanding officer, as provided for in the directive defining the unit's mission. He is seen by a military psychiatric social worker, who explains that the unit interviews all soldiers who have been AWOL prior to courts-martial hearing, and that the army is concerned about his AWOL because it renders him as ineffective as if he were a casualty.
>
> Here the social worker explains the basis for the army's concern, quite apart from the fact that the AWOL was a violation of an Article of War (which is equivalent to civilian criminal law). The army is concerned about the factors that would lead a soldier to expose himself to courts-martial. The army is interested in knowing what is involved in a soldier's subordination of his responsibility for training or other duty. The soldier must have some important reason which he felt took priority over the demands made on him by the army. If he has a problem with which the army can help, then he will be able to be a responsible soldier; if not, the army would have to know that also, since it would materially affect his future effectiveness as a soldier, and proportionately affect the efficiency of the army. This is the reason for the interview and the responsibility of the worker.
>
> The soldier may be apprehensive and may have felt that this appointment was for the purpose of "reading him the book." He may tell, then, that he has received several letters from his mother in which she complained bitterly of his absence, and of her inability to make ends meet since his support had ceased. He may have felt that he could "straighten things out" if he went home for a week; perhaps a brother not in the army could give more assistance than he had been giving. The soldier did not think his C.O. would give him permission to go home for this purpose. Or he may have started home after a few drinks which made him unhappy about the problem over which he was brooding. His problem may have been compounded by inability to absorb a course of instruction or to make friends in his barracks, an argument with another soldier, or a number of other precipitating factors.

Here we see a problem that most soldiers have in one way or another upon finding themselves in the army. It is diffi-

cult to realign civilian ties and responsibilities with those of the army. This adjustment takes place slowly as the civilian becomes a soldier. At this point, however, the soldier we have been discussing has a problem with the army, too, and is quite concerned over the outcome. The stake that he has in being a soldier may become clear to him for the first time, and he may begin to realize what it means to be in uniform. This may be a painful experience, and he has the problem of adjusting to it.

The military psychiatric social worker explains that it is his job to understand the causes of such interferences with military responsibility as this, and to make them known to the army. The question is, What kind of soldier is he? What can be expected of him? Can the army count on him for consistent performance?

The soldier slowly becomes aware of the real questions involved, and of the fact that the military psychiatric social worker and the army are not interested solely in whether or not his act is good or bad, whether he was right or wrong. The army's concern goes beyond the legal implications into the question, What is the soldier like as a human being? Does he possess the qualities that make for good soldiering? Can he be trusted with a mission on which the lives of others depend? Is he being trained for the right job? Has he had too much or too little responsibility? Can he be helped with his problem? Is a change of assignment indicated? Is he emotionally ill, and is his offense symptomatic of a more deeply rooted personality problem?

This concern on the part of the military psychiatric social worker is the basis of his relationship to the soldier. The worker senses the soldier's distress, and the fact that he wants a solution, both of his home problem and of his now preoccupying army problem. The worker lets him know that he cannot directly help with the home problem, but that there are agencies in the community that can help his mother. The soldier can suggest to her that she seek this help.

Throughout the interview with the soldier, the worker learns about him, piecing together the picture of a person who has been fairly well organized most of his life, but who

does show a dependence upon his mother which received a severe jolt when he was inducted.

For the first time the soldier begins to realize what is now expected of him. He asks the questions that have been troubling him about the army's requirements for standards of performance. He weighs these carefully and wonders whether or not he can really carry on and devote himself to his job as a soldier. The worker discusses his problem with him and may let him know that it is one encountered by other soldiers early in their army experience. He may point to some of the soldier's accomplishments as a civilian as an indication of his capability.

The interview centers around the relating of this incident to the possibility of the man's becoming a soldier. He is informed that a statement will be made to the courts-martial board that will include his feeling about his army adjustment as he sees it, and that it will be up to them to use the statement as they see fit. It is also explained to him that he will see the psychiatrist, the director of the unit, who will have to give final approval to any evaluation submitted.

In this hypothetical case, which is typical of many actually encountered, some of the elements of the treatment process emerge. The soldier finds himself in an official relationship with the army, discussing his very individual problem of adjustment. This in and of itself is an important factor in improving his understanding of the army and his identification with it. As he is able to talk out and thereby clarify his problem, he derives strength from the sharing of his difficulty with the army, as well as an understanding of some of the elements involved. He begins to see his responsibility as a soldier in relation to being a husband, son, or father. The experience becomes positive rather than merely punitive.

The army, on the other hand, has an opportunity of evaluating at close range the soldier's military potentiality and of acting on the basis of its own expert's evaluation in the matter of further training or action.

Depending upon circumstances, there may be several contacts between the military psychiatric social worker and the soldier, and several services within both the unit and the

installation may be brought in during the course of a case. The soldier learns that he cannot carry two responsibilities at the same time, particularly when, in trying to do so, he becomes involved in a conflict between the two.

In this case we see the military psychiatric social worker working first from the basis that his is a service to the army, which must know its men and their capacity for soldiering. In rendering this service, however, he becomes of service to the soldier also. He reduces the threat of "army" to simple concepts which become understandable to the soldier. This twofold service comes out clearly in the case that follows:

> This soldier, a nineteen-year-old, was referred by his commanding officer after returning from AWOL. The interview revealed that he came from a rural area and had farmed all his life. He was marginally illiterate (a fact of which he was ashamed, and which he had concealed at induction), and became concerned when he had not heard from his parents in some time. As the oldest son, he had carried a large part of the work of the farm, and had remained close to home. It appeared that as army requirements brought on more situations in which his literacy handicap made him inadequate, his concern over his family increased proportionately, until he went AWOL.
>
> In this case, a non-verbal test given by the unit's clinical psychologist indicated that the soldier had superior native intelligence. The psychiatrist's opinion to the courts-martial board, based on conferences with the military psychiatric social worker, was that the soldier was fundamentally capable of responsible behavior. He was sentenced and fined without confinement, and was seen by the unit again. Here he was helped to a further understanding of his problem, and on the basis of further evaluation, and of his ability to relate to the army through the social worker, the unit referred him to the special training unit for literacy training.
>
> After completion of this course, he was again seen at the unit, and through training memorandum, was assigned by the classification section to a school within his capabilities. He was seen twice afterward during his specialized training period, and completed the qualifications for an army specification serial number.

The following case will further illustrate how the military psychiatric social worker's responsibility to the army can be a positive, dynamic factor in the helping process.

> This soldier was referred to the unit because he had twice fallen from a telephone pole, and the officer in charge of the class in pole-line construction could not let him continue. He showed himself at once to be a sullen and somewhat fearful person. The military psychiatric social worker told him why he had been referred and stated that it was the social worker's job to look into the problem with him. The worker

had also learned from the officer in charge that this soldier disliked pole-climbing intensely, and that he was defiant in his refusal to carry out instructions.

The worker told the soldier that it was not difficult to see that things were all wrong for him. As one of the services of the unit, the worker explained, reassignment to a different job could be recommended, providing the soldier was eligible. The soldier took hold of this idea to express his desire for the radio operator's course, and his complete distaste for his present work.

The social worker brought out the concern that was felt over his having fallen from the pole twice and said that he looked like the kind of person who could climb well (he was young and very wiry in appearance). The soldier laughed, and said that the reason he was picked for this job was because he had been a timber-jack in the Northwest for a while.

As he warmed up to a discussion of himself, he went on to say that he had done this type of work long enough as a civilian. Now in the army he wanted to improve himself and would refuse to coöperate until he got what he wanted. The social worker explained that if he were eligible for reassignment, this could be brought about. The soldier could not understand why there should be any question, and was ready to end the interview on this. The social worker, however, pointed out to him what his responsibility (as a representative of the army) now became. If the soldier could not be a pole-linesman—and the worker would grant him that this might be so—then the worker would have to make the recommendation that he be taken out of this work and be reassigned.

The soldier wanted to know what would happen—would he be made a radio operator? The problem was then formulated as follows: If he wanted to see whether he would be eligible for the radio-operator course, he would have to take tests; if he passed with the required score, then the change to this type of work would be recommended; if he did not, he would have a chance of going back to pole-climbing on a trial basis, or be at once assigned to an unskilled job.

This presented a real problem to the soldier and brought out his basic need to be successful in work above his capacity. A good deal of feeling came out about how all his life he had been frustrated in not being able to do a "big job." The army, he had thought, would give him his chance, and he was miserable in finding himself up against the same problem again. The social worker explained that he understood this, and would help the soldier in any way consistent with army policy.

The soldier failed in his tests and came in to tell the worker about it even before the latter had been informed by the unit's psychologist. The soldier was dejected and thought that he had better return to pole-climbing. Again the social worker expressed his doubts as to whether or not he could recommend the soldier's return to this work or should, in view of the soldier's feeling about it, suggest that he be taken out of this job.

What the worker did here was again to point out his own responsibility to the army. If the soldier continued to have such strong resistance to this work, then he might actually harm himself in going on with it. This was discussed with the soldier, who felt some doubt

himself about wanting to go on with the work. A trial period of one week was set, and it was agreed that at any time before the end of the week, he could come in to request a change.

The soldier kept his appointment after a week. He was somewhat sheepish at first, but then told how he was the best pole-climber in his class; no one was going to outdo him, and the officer in charge had used him to help instruct others. This was verified by the worker. Later, the soldier qualified with an "excellent."

The soldier and the worker used the opportunity to discuss all that had occurred in this short time, and the soldier gained some insight into his problem of always feeling frustrated because he was not doing what he thought he could do if he were given the chance.

The rôle of the military psychiatric social worker in this case is clear. Again his primary concern was the army. We see that though this soldier's basic problem was a long-standing personality conflict, it could be resolved, as it was reactivated by his problem of army assignment, almost in the same fashion in which he had been able to handle it in making a good community adjustment. Thus, the worker, in meeting the needs of the army, was able to help the soldier also through his ability to understand the personality motivations of the soldier and to relate them to his problem of army adjustment. This is not always possible, especially when an army-precipitated problem touches off basic personality pathology that requires prolonged psychiatric treatment.

A soldier had been AWOL twice and had received company punishment on several occasions for minor infractions of discipline. He was a problem to his company commander, to his first sergeant, and to others who were trying to learn to soldier with him. In one form or another, this type of soldier is representative of a small group who are a constant source of concern to those responsible for them. In such cases, the unit performs a valuable service to the commanding officer by relieving him of the problem of making a decision. These men are ill, usually suffering from severe neurotic disturbances. The average line officer frequently has no other recourse but resort to discipline. This may be repeated often, but he is still left with the problem. It is a psychiatric problem that requires diagnosis and a recommendation for disposition via appropriate army regulations.

Here the military psychiatric social worker's job becomes one of learning and evaluating all the facts and circumstances of the soldier's problem, including, usually, a social history which focuses upon all the factors that relate to the present problem and that will aid the psychiatrist in the diagnosis. Of major importance is the question whether the problem is neurotic in its present manifestations or is one of "constitutional psychopathy." This is important, not only clinically, but also because it will determine the "line of duty" status and type of discharge a man may receive.

Even in the case that is headed toward discharge, it is possible for the psychiatric social worker to help the soldier if he can accept the fact that this man may be an ill person whose problems with his army adjustment are not soluble and may continue to create further difficulty for him when he returns to civilian living. Often the soldier who has serious problems of adjustment, particularly the neurotic, is in a constant state of discomfort and suffering. He may have strong conscious feelings of guilt over his failure as a soldier and may desire another chance, to make amends. The worker can here help him to a recognition of the fact that the army does not hold him at fault because of his illness, and that he may be, and usually has been, quite useful in civilian life. The worker can also interpret to army lay opinion why it is that this soldier, although he promises to make good, is a poor risk, and should really be discharged both for his own and for the army's benefit. Herein the psychiatrist's professional responsibility is maximal.

A Validation of Army Policy.—With the progress of our military efforts, there has been a shift in the activities of our armed forces—a gradual change from training to combat activity. With it has come the return of the veteran, the combat casualty, including the so-called neuropsychiatric casualty. It is of no small significance that the war department, through the Surgeon General's Office, has initiated various efforts in the direction of treatment and convalescent care to meet the government's responsibility toward these men. The aim has been twofold—to help as many soldiers as possible return to useful army service, in order to conserve skilled and experienced military personnel; and to help

those who are unable to return to duty toward a constructive separation from the service. The emphasis upon return to duty of the neuropsychiatric casualty has in itself a sound therapeutic basis, as we shall see.

A policy of discharging those who cannot be of further service is of benefit both to the army and to the soldier when it is guided by sound psychiatric principles that are in keeping with reality requirements. From their experiences in dealing with neuropsychiatric casualties, both overseas veterans and soldiers within the continental limits of the United States, psychiatrists and military psychiatric social workers have crystallized certain fundamental concepts.

Much has been and more will be written about the neuropsychiatric casualty—the dynamics of breakdown, the symptom pictures, and the treatment, medical and psychiatric. One conclusion can be drawn—it is that the neuropsychiatric casualty is a medical problem for the army, and that only a medically supervised program of treatment can be applied. This is the basis for the establishment of neuropsychiatric reconditioning centers and convalescent hospitals. The simplicity of this concept belies the complexity of the problems that must be overcome in order to carry it out.

Medicine in the army, as in civilian life, has been the function of the hospital and the practitioner's office. Psychiatry and social work in civilian life have extended into the community through mental-hygiene clinics, social agencies, and out-patient clinics. In the army there has generally been a less clear working relationship between the psychiatrist and the line officer. A soldier is either well enough to be on duty or sufficiently ill to be in the hospital—in other words, it is a question of bathrobe or barracks.

As neuropsychiatric casualties began to present an increasing problem because of their numbers, and questions of treatment and disposition came up, such special installations as those above mentioned were established. Their mission has been that of returning as many men as possible to duty, a task that requires, in addition to clear-cut criteria for differential diagnoses, a realistic program of treatment, as well as an understanding of the personality reactions of the army neuropsychiatric casualty.

It was in this connection that a number of military psy-

chiatric social workers, with mental-hygiene experience of the replacement-training "era," under psychiatric direction, developed a program of neuropsychiatric reconditioning. Such a program was naturally closely affiliated with other medical facilities, in this case the resources of a general hospital. Upon initial screening, however, those who were not so ill that they required ward hospitalization were given their uniforms and organized into a line company, with company commander, first sergeant, and other necessary administrative personnel.

The philosophy underlying this step was the belief that many of these men could eventually be returned to duty as useful soldiers. Various observers had found that some soldiers who had suffered a "nervous breakdown" could be returned to duty and continue to function effectively, although often under less strenuous and dangerous conditions. It was also known that many men desired to return to their outfits and resume fighting, but that the basis for this was often a sense of guilt and a feeling of having deserted their comrades. Such motivation could not be accepted as being psychiatrically sound, since the soldier would be operating on the basis of guilt, an unpredictable motivation. This was more clearly evidenced when some of the men who were thus returned to duty soon broke down again, and were subsequently hospitalized.

Neurotic reactions that interfere with a soldier's performance of his job have been found to be, in their disabling effects, not unlike other neuroses. If one agrees that the neurosis or the symptom formation has compensations for the individual in as much as it is a protection against the further pressure of a reality situation that has passed his threshold of tolerance, this would seem to offer a workable explanation of many of the breakdowns that occur among soldiers. There are numerous other determinants, all of which contribute to the final breakdown that precludes further immediate duty.

Many soldiers have had neurotic personality structures all their lives. Of the majority who break down in the army, it may be said that they made a relatively satisfactory adjustment as civilians. As for those who did not, the army has

in most cases found them unsuitable prior to their assignment to combat outfits. This in a large measure was the mission of the mental-hygiene unit in the replacement training era. At present the program is more concerned with neuropsychiatric casualties in soldiers who have given good service in the army over a period of time and whose breakdowns occurred in or near the zone of actual combat. Our discussion will, therefore, be primarily concerned with the combat veteran, since he presents unique features not present in other neuropsychiatric cases. On the basis of experience in dealing with hundreds of neuropsychiatric casualties, one can say that the common or causative factor appears to be the soldier's inability to endure, any longer than he already has, the tremendous threats to personal security presented by combat duty. Fatigue, morale, letters from home, the success or failure of his oufit, traumatic experiences, and many other factors may be the external precipitant in the development of new, or an acute manifestation of old, neurotic symptoms.

By the time the soldier returns to the United States there are, usually on the overt emotional side, expressions of a generalized hostility, psychosomatic complaints, negativism toward anything and every one, desire to be discharged or to return to duty at once, and, often, not far below the surface, a great deal of guilt. This is sometimes conscious, but more often it is manifested in aggression, a pushing away of all reality for fear it might harm, a fear of never again being capable of doing anything, and above all the formation of new, or the intensification of old, psychosomatic symptoms. There may be headaches, backaches, gastrointestinal disorders, hysterical symptoms, conversions and compulsions, to mention only a few.

Whatever the degree of the disorder, it is the responsibility of the army either to cure the soldier—or to help him toward improvement—or to separate him from the service in the most constructive manner possible. This is the mission of the neuropsychiatric reconditioning or convalescent center. How is it carried out, and what is the job of the military psychiatric social worker? How does he fit into this medical-psychiatric program? The case-worker is neither physician

nor psychiatrist. He renders a service to the army, to the psychiatrist, and to the patient by the manner in which he uses his experience, his technique, and his training.

If we conceive of the job in the neuropsychiatric reconditioning center as one of diagnosis, treatment, and disposition, then the case-worker's rôle can be demonstrated. As stated before, it is necessary to know a great deal about the feelings of a combat soldier, and about his problems, previous diagnoses, and clinical findings (usually available in charts from previous hospitals). The military psychiatric social worker must know what the army policy is, how it regards the soldier's emotional disability. Can he be of further military service, or do his symptoms prevent his performance of an assignment of which he may be capable? How does the soldier-patient view his problems? What is his attitude? Has he any insight into the nature of his illness?

The soldier comes to the initial interview, as previously described, after he has been given an orientation as to the purpose of his transfer to the installation. The psychiatrist has seen him and feels that he is a fair risk for rehabilitation. This opinion is noted in the soldier's chart, and he has then been referred to a military psychiatric social worker. This is the point at which the case-worker goes into the interview.

A soldier, twenty-one years old, has spent two years in the Southwest Pacific with an infantry outfit. He has been in the army three years. Six months ago he began to feel dizzy and to get restless. He talked a great deal and his friends began to worry about him. The chart read that he was referred to the medical officer when he was found wandering around aimlessly one evening.

On examination he complained of severe pains in his head and back, with loss of appetite. It was also learned that he had been quite sullen, getting into fights which he seemed to provoke, and was "through with his outfit and job." He was referred to the psychiatrist, who ordered him sent to a rest area. Hospital records here indicate rapid improvement, disappearance of symptoms, and a desire to return to his outfit; and after about six weeks in the rest area, he returned.

Shortly afterwards, during a combat mission, he was found unconscious without any physical injuries. He was hospitalized and ordered to the Zone of the Interior (United States). Diagnosis: psychoneurosis, anxiety state, severe, with conversion features. All medical examinations were negative for organic findings. Other information gained from his medical records and two hospitalizations in the United States prior to

transfer to the reconditioning center, revealed the following facts: This soldier disliked his army assignment intensely; he was a machine gunner, and he felt a bitter resentment toward the army for not giving him a chance to learn a trade.

Although his headaches lessened with his return to the United States, they persisted intermittently. The soldier had expressed some willingness to return to duty, but seemed quite ambivalent, and a definite decision was not made. Instead, he was referred to the neuropsychiatric reconditioning center.

The first job of the military psychiatric social worker was to evaluate the chart and study the service record. What he got out of this was the following: This young soldier had enlisted at the age of eighteen. His family was fairly well-to-do. The parents ran a bakery. There were several older brothers and sisters. He did well for a long time as a soldier, and there were no apparent predisposing neurotic factors. His breakdown and symptoms were not uncommon. He seemed to have recovered after the first incident and again improved on his return to the United States. His records showed that although he had completed a commercial course in high school, prior to enlistment, he had not pursued this any further. Considering his intelligence level, as revealed by army scores, it appeared that he had been well equipped to follow up his studies with a job in this field, had he so desired.

On seeing the soldier two days after his arrival, the social worker noted a youthful, tense individual. He spoke rapidly and was filled with anger at having been in several hospitals. "Nothing had been done" for him; he had "terrific headaches"; he couldn't walk much because of backache; he could not stand the sun; and above all he was going to "blow his top" if any one gave him orders.

The worker allowed him to finish and then asked him if he knew the reason for this interview. He said that he did not, and if it was to get him back to duty, then that idea "may as well be thrown out right now." He wasn't "fit to be a soldier," and unless the army "cured" him (which it had not done as yet, and which he did not think it could do), then we were just "wasting" our time in keeping him here.

The worker indicated that he knew a little about the soldier—where he had been and how he had finally come here; also that he could see that the soldier was pretty discouraged and wanted some decision made. He added that there was a program here of company activities—sports, short hikes, lectures, discussion groups, and recreation—but that apparently the soldier was not interested. The soldier repeated that he was tired of doing things, and if he was going back to duty, then why not send him now?

The social worker agreed that perhaps he might go back to duty shortly, but stated that first it was the army's policy to determine whether he was fit to return, and if so, what duty he was capable of performing. This meant that some time must elapse before the evaluation could be made. The soldier relaxed visibly, and then wanted to know what this was all about. He said he had thought about "the orientation," but did not know what to make of it. Were men sent back to duty? Were they given medical treatment? These headaches were terrible; if he did not have them, he might be able to think of returning to an army job. He knew that all the medical examinations

had been negative, and he felt that every one was trying to talk him into thinking his headaches were imaginary.

He seemed to be waiting for the worker to tell him that this was the case. Instead, the worker agreed that he had headaches, whether the examinations showed the reason for them or not. If the soldier said that they existed and felt the pain, then that was good enough for the worker. However, the worker did have confidence in army medical officers and knew that if there were medication for his headaches, they would not refuse him the necessary treatment. He agreed to this, but he did have the headaches.

The worker then observed that he seemed to be "stuck" all the way around, being in the army, having headaches, and getting no relief even after long hospitalization. The soldier wondered if there was, therefore, any point to the whole business. The worker agreed that there did not seem to be any way out. Here he was, still in the army, and stuck with a big problem. Had he ever thought of any way out? The soldier's response was that it was not that he wanted to be out of the army, but what could he do in his condition?

The worker commented on the soldier's long and excellent army service and his awareness of the change that had taken place when he began feeling sick. The worker also said he knew that the soldier had enlisted right from high school, after successfully completing a commercial course. The soldier explained that he had enlisted because all of his friends had, and then admitted that his father had wanted him to go into a business that he had always disliked. Thus, enlisting prevented him from entering a career that he was only too happy to avoid. Once in the army, he had felt some remorse, but this had been absorbed by the fact that he was doing his job as a soldier.

After about two years, however, he had begun to feel out of things and deprived of opportunities for making something of himself. He had always wanted to continue his commercial interests, and began to blame the army for making this impossible. He had tried for a reassignment to a clerical job in the army, but had been unable to effect a change of assignment. As time went on, things that formerly he had been able to take in his stride upset him, and it finally ended in his first breakdown.

These details are not presented with the idea of bringing out the causative psychodynamics in the case. But it was important for the social worker to recognize the following trends in this soldier. He had been a relatively adequate person, both as a civilian and as a soldier. He was interested in making the best of himself. In one interview he had changed from a hostile, negative person to one who could relate to the social worker as long as his defensive reactions were not stimulated by more pressure. He could begin to believe that the army was sufficiently interested in him to have some one talk with him without requiring him to do things.

The turning point came when he asked how any one could help him, and wanted to know what, if anything, he could do, if he remained in the army. It was explained to him this did not need an "on the spot" decision. He had just come to a new installation and perhaps, as a first step, he might try to go along with the program. He asked what there was for him to do, and was given a brief description of the activities available. He voiced some objections to the games and

athletics, and was not urged to participate beyond his own feeling of ability to do so. The social worker indicated that all administrative matters, such as issuance of passes, regulations as to when he had to be in at night, and so on, were questions that would be answered by the first sergeant or the company commander. The worker would see him in a week.

At this stage of the process, the company program came into the picture. A very close working relationship was maintained between the company and the social worker, and during the week it was learned that the soldier was adapting himself well. When seen again by the social worker, however, he spoke of being restless; his headaches had become worse; and he found the program of no particular value.

The worker remarked that he had been moving around with such speed and activity during the past few years that all of this must seem very dull and uninteresting. Yes, he wanted to do something, get back to duty. The worker asked him what he thought he was going to do when and if he got back. He did not know, but anything would be better than this. The worker asked if he meant that return to the infantry was what he wanted. He said he could not return to that because of his health.

Then he suddenly found himself face to face with the big question: What did he really want to do? Where was he in relation to himself, present and future? He began to talk with much concern. Here he was, over twenty-one; he had never learned anything—it was all the army's fault. He wanted to get into something that would be of use to him later. He did not even know whether he could do clerical work because things got on his nerves. He would like, though, to try an assignment in a clerical job. The social worker then recognized the difficulty he had in making a decision, and indicated that there might be a way of finding out whether or not he would like such a job.

The worker described one of the group-therapy opportunities in which the emphasis is on a discussion of army clerical jobs and the problems of soldiers in relation to them. This form of group therapy is based upon the following principles: Men with similar army backgrounds or previous job assignments are grouped together for discussion purposes. There is no specific instructional purpose to these groups. The group therapists' orientation is toward stimulating discussion with these patients about their army problems. The average soldier will take part in these groups and express his complaints and negative feelings toward the army, but this may very easily result in a nonproductive expenditure of feeling. For this reason the discussion, through the awareness and effort of the military psychiatric social worker, is tied to a relationship in the army that may have a positive meaning. In this case it was the field of clerical work in the army.

In this technique a soldier who is intensely preoccupied with his complaints is helped to talk about them as they have affected or may affect his interest and performance in a certain field of work. During the process, he will have ample opportunity to express his negative feeling, but he will also be a part of the inevitable group interplay through subtle controls that the group therapist exerts. He will learn about the difficulties of others in jobs similar to his own, also the satisfactions that others have experienced. Thus he will be taken from a one-sided view of his job. He will learn about the many different clerical jobs

in the army from others who have performed them, and can measure his own interests and abilities against theirs. Under the skillful direction of the group therapist, he can begin to formulate his own attitudes, decide on what he really wants to or can do, and then will return to the military psychiatric social worker, who will work with him on an individual basis, considering with him his place and future in the army. He is helped, not forced, toward a positive orientation, as a result of reference to such a group, as planned between him and the case-worker.

It was on this basis that the soldier was referred to the type of group described. Contact with the group therapist and further interviews with the soldier brought out the fact that he was becoming interested in a particular type of clerical job—that of "stock-control clerk." There was further mention of his complaints, but after three weeks his attitude and general demeanor had changed. His nervousness had decreased visibly; he said that he did not think about his headaches as much as before; and he was beginning to show some dissatisfaction with the program, saying that now that he had decided what he would like to do, he wanted to begin as soon as possible.

The worker raised some question about his eagerness, and asked him whether he had considered the possibility that his headaches might interfere with his job. The soldier said that they probably would from time to time, but that he could not be an invalid for the rest of his life. There was then some discussion of illness, and how it interfered with one's interests and activities. The soldier was aware of this, but he had actually demonstrated to himself here that he could get along outside of a hospital, and in this way had regained a measure of self-confidence.

The contact ended with a formal statement of the soldier's qualifications and interests and a recommendation for the job to which he should be assigned on return to duty. This was the concrete evidence of service to the army and to the soldier. The psychiatrist reviewed the social worker's contacts, and saw the soldier for final diagnosis and approval of the recommendations.

This case has been presented in some detail to show the military psychiatric social worker's rôle in the treatment process. It is clear that the social worker must himself have a strong conviction as to the inherent personality strengths of these soldiers who have broken down. Their neurotic symptoms are often severe. In the case of battle reactions—which manifest themselves in night terrors, inability to sleep, extreme sensitivity to noise, restlessness, battle dreams, speech defects, partial paralysis, and many other symptoms—the clinical pictures of these men may too quickly lead to a negative conclusion as to their chances for recovery.

It is important to realize that a majority of these soldiers wish to get well, or, in case-work terms, are eager to regain confidence in themselves. Some see themselves as having

failed their country, their unit, and their friends. Some have still not been able to proceed emotionally from the point at which they were blown out of a fox hole. Above all, their strongest asset has been their identification with "an outfit," which has come to be synonymous with everything that is of value and importance to them. Their guilt is sometimes on the surface, though often submerged in their symptoms. They are men who in the majority of cases have known the satisfaction of a relatively good adjustment as civilians and who in the army gave adequate service until their breakdown. Without a realization of this on the part of the therapist, any treatment effort will be handicapped by the therapist's own prejudice or lack of understanding.

These men want to be well—but they are also fearful of the consequences of getting well. Their fear and inability further to tolerate the dangers of combat, or the conditions of army life in general, do not necessarily spell weakness. Their symptoms are a defense against danger to themselves and thus have a utility value for them as individuals.

To illustrate, in the soldier whose case we have just cited, there was a strong urge to regain a feeling of worth, but his symptoms would not abate without a satisfying, less threatening substitute. The military psychiatric social worker knew that insight alone was insufficient to help him. There was too much emotional reinforcement for him to be able to give up any part of his symptoms before having an opportunity to try himself in a group situation.

This points to the need for an adequate case-work, group-therapy program that is geared to the army, and that the soldier and the worker can use in a simulated "trial of duty." This concept has been found to be an intermediate step in a reality progression of diagnosis, treatment, and change. It must be rooted in the army, since the illness has been precipitated by army experience and the patient is still a soldier, with the problem of adjusting to army reality, even though he is a soldier-patient. Such basic activities as clerical jobs, mechanics, administration, cooking, and so on will tie him into a reality that he has health enough to meet with increasing satisfaction.

The neuropsychiatric casualty will in most instances not

be returned to a combat unit. He will usually be reassigned, if he returns to duty, to service within the continental limits of the United States. Thus, the installation whose mission it is to help the neuropsychiatric casualty to return to duty must have trial-of-duty opportunities within its program.

> A soldier had been with an engineers outfit in France. He went through several missions and then turned himself in to the field hospital. He showed marked symptoms of nervousness and depression, suffering also from battle dreams, headaches, and an inability to sleep. His outward demeanor was that of a person who had lost interest in things, and who felt himself incapable of any further service in the army. He was also vague as to what he might do if he were discharged. He had, in a word, completely lost confidence in himself. He feared risking himself in any kind of activity, and his physical complaints were the conscious basis for his incapacity. The transfer diagnosis, at the time of admission, was "psychoneurosis, battle reaction, with depression and schizoid features, moderately severe."
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> After two weeks, during which his participation in the general program was almost minimal, he and the military psychiatric social worker engaged in a discussion of things that he might try to do. Showing an interest in something along the lines of his former civilian jobs, he thought that he would like to try working in the supply room for a while. A few days' trial in the supply room was, therefore, arranged, to be followed by a further evaluation of his experiences.
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> Much to his surprise and gratification, the soldier took to his job with a great deal of ease, though he did have to "rest up" several times during the day. Gradually his work become steadier, and the officer in charge expressed the opinion that he seemed quite capable of performing this job in a regular-duty assignment.
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> During several interviews with the military psychiatric social worker, the soldier found that his symptoms either had disappeared or were at least not as annoying as before. He could even accept the idea that they might continue to a greater or lesser degree, but he knew now that he could carry on even though he had them. When he was discharged to duty, he was assigned as a supply clerk, and follow-up reports showed that he was making an excellent adjustment.

One of the conclusions to which this method of treatment leads is that it must be related to the reality in which the soldier finds himself. Treatment of emotional illness in the army, no matter how skilfully done, must be based upon the fact that the patient is a soldier in the army, and subject to its requirements. He will not have an opportunity to get well solely through the office interview, unless the content of the interview is used in conjunction with the services of the army. These services, a satisfying reality, are provided through proper placement, and trial-of-duty assign-

ments for diagnostic and treatment purposes, followed by reassignment, upon return to duty, to a type of work that is not likely to reactivate symptom formations. In addition, provision is made for participation in creative educational and recreational activities, which give the soldier the satisfaction of performing as he was able to prior to his breakdown.

Through the differentiated use of these activities, based upon understanding of the soldier's problem and the requirements of the army under psychiatric and medical guidance, the military psychiatric social worker has an endless number of opportunities to create a case-work service that may help the soldier and the army. It should be emphasized, though it may seem self-evident, that the social worker must always rely to a great extent upon his own resources. He must always be inquisitive about finding the answers to questions of army policy that he does not understand. He must know the problems with which he is working, the emotional reaction of the soldier as seen in the installation or echelon in which he is assigned to duty. He must constantly maintain an awareness of these dynamic factors, while keeping the army's primary objective in focus. His work must be effective within the limits of the allotted time, and streamlined as to procedures in order to help the army and the soldier. The army must operate on the basis of practical results; they must be tangible and must meet a need related to the army's mission.

THE RÔLE OF THE MILITARY PSYCHIATRIC SOCIAL WORKER IN RELATION TO DISCHARGE

The military psychiatric social worker is always confronted with the question of a soldier's suitability for military service, a question that his unit may be called upon to answer wherever it functions. In the replacement training center, the decision to recommend the discharge of a soldier will usually be made when he is found to be incapable of meeting the requirements of military training, either for emotional or for physical reasons. If for purely physical reasons, the discharge would be effected through medical channels.

Where a mental-hygiene unit is operating, discharges for

psychoneurotic reasons are likely to be recommended through the process of being brought to the attention of the unit, as defined in the official directive by which the unit functions. Since the unit is responsible for the treatment of the psychoneurotic, it naturally follows that it would have the job of recommending discharge when the soldier is not amenable to treatment within the prescribed limits, or shows little potentiality for useful service.

In either case, the military psychiatric social worker may carry a variety of responsibilities in relation to such a process. He may, if compiling a history for the psychiatrist, provide the psychiatrist with the facts available from the soldier's military records, from the worker's interviews with the patient, and from the reports of the officers who have been supervising and observing the patient's performance as a soldier. The social worker may also be given a rôle in the treatment process itself after conference with the psychiatrist. This may mean that the case-worker will see the soldier in periodic interviews, to evaluate his adjustment with him, to discuss his activities in the program, and to formulate an evaluation of the patient's abilities for military service.

Here the social worker makes use of his knowledge of the relationships between the diagnosed condition, as stated medically, and his understanding of army requirements. One cannot be considered without the other. A diagnosis, however detailed and complete in regard to the psychodynamics of a case, is academic unless it can be expressed in relation to the setting that it affects or through which it is influenced. Some soldiers with an anxiety neurosis may be quite capable of further duty, and if properly assigned, will benefit from further military service. Other soldiers with the same diagnosis may be totally incapable of military duty because of other factors in their personalities or in the military situation.

The decision to initiate discharge must be based upon a multitude of factors, all of which, in the final analysis, become very specific. When a soldier's symptoms are acute, as in the case of hysterical attacks, sudden depression with suicidal thoughts, or a homosexual panic reaction, the decision to

recommend discharge is clear. Clinical pictures such as these, and others that may become manifest in an acute or chronic form, are for obvious reasons beyond the scope of military responsibility, even if it were not important to economize on time and personnel. Men so affected are very obvious military risks, and their suitability for service, even with long-time intensive psychotherapy, is questionable. The social worker's job here becomes that of corroborating the facts from the social history, the reports of witnesses, and the immediate symptom picture.

The mental-hygiene unit here is charged with explaining why this man is not amenable to the treatment available and why he is a risk to himself and to the army. Differential diagnosis in these cases is not difficult for the militarily trained worker.

There is a large group of soldiers with personality disorders who in many respects do not deviate markedly from the average neurotic person, but in whom military factors have produced more severe reactions or have reactivated old ones. A patient of this type may have been diagnosed as psychoneurotic (this would appear on military records available to the unit) before coming to the attention of the military psychiatric social worker or, if a new patient, he may manifest obvious neurotic traits. In either case, the diagnosis is made and confirmed by the psychiatrist. The social worker may then have the job of evaluating the total situation with the soldier. It may be several weeks before a final decision can be reached.

In a training camp, there are many so-called "trial of duty" assignments. The military psychiatric social worker, through the unit, may effect change of assignment or of job, or may help in the reorientation of attitudes, through a clarification of the army factors that have become a problem for the soldier. The worker knows the soldier's problem, his job and its requirements, the officers and men with whom he works, the responsibilities of his future or present military assignment, and the possible alternative assignments or conditions under which he may be able to serve, as defined by present army policy and directive. These are the military psychiatric social worker's working materials, his tools which

are army-approved by the unit's authority under which he functions. All of this is weighed with the soldier's problem, his interests, his fears and worries, his physical condition, his intellectual potentialities, and many other factors that go to make up that composite individual, the soldier. In this manner the social worker, the soldier, and above all the army find an answer to the question of the soldier's military suitability.

Through all the services that can be offered, the considerations that the military psychiatric social worker and the soldier can engage in, the measures that can be used at once on a trial basis, "to see," the worker finds himself challenged to call upon every bit of skill he has ever learned. The relationship is a changing one, demanding constant reëvaluation in terms of the reality of which it is a part.

The reason this is discussed here under discharge is because the most important function of the military psychiatric social worker in the discharge process is the treatment preceding the final decision to discharge. How well this can be carried on may depend entirely upon the setting and facilities within which the social worker finds himself. In any event, the decision to discharge a soldier should be arrived at only when treatment is not feasible or when it has been tried and has failed.

Another function of the military psychiatric social worker is that of helping the soldier toward a constructive separation from the service. At the present time, this function does not come within the job responsibility of most military psychiatric social workers, since the Veterans Administration and other related civilian agencies have the major responsibility for bridging the gap for the soldier who is returning to civilian life. The army, for all practical purposes, completes its responsibility with the discharge.

The military psychiatric social worker can do much to help the soldier who is too ill emotionally to remain in the service by making the final stages of military service as constructive as possible. He can emphasize the soldier's strengths. It is important to recognize that the emotional disability that precludes further military service is frequently regarded by the soldier as being all-encompassing.

This is, after all, the way it feels to him when he finds himself unable to meet a soldier's reality. His guilt will manifest itself in feelings of worthlessness (which the army has in a sense proved to him), and in a fear of the attitudes and competition of civilian life which looms ahead. It is extremely important for the social worker to help the soldier about to be discharged to realize that military disability is not to be equated with civilian disability. This the worker is not able to do directly, particularly if the soldier has not yet been approved for discharge via pertinent regulations. But the fact of his failure is obvious both to soldier and to social worker. The implications as to its totality can, however, be greatly cushioned by the way in which the social worker discusses it.

When first interviewed at Company ...., this soldier presented an extremely well-poised appearance, although obviously controlling a great deal of tension. He recounted his foreign service in a matter-of-fact manner, with general understatement. In an offhand way, he briefly mentioned the "strategic retreats" at Narvik, Norway, and Dunkirk, and subsequent operations in Africa in which he had seen action. He also mentioned briefly his three periods of hospitalization, once for "shell shock," and a seven-month convalescent "rest." He spoke of a somewhat "jittery" feeling, but felt that everything would be all right once he returned to action.

He expressed some impatience with garrison life, but also verbalized general confidence about assuming the responsibility of an officer, and offered the fact that he had been an officer in the R.A.F. as evidence of his ability. He expressed real concern only about the adjustment of his "British wife," who had returned with him to this country.

During the second interview at the mental-hygiene unit, the soldier expressed a great deal more feeling about himself and his own problems. He broke down several times, and stated that he frequently did this now when he felt overwhelmed by his problems. He was aware of being disturbed to such a degree that he knew he could never face action again. He said that his return had been made with the proviso that he be retained in service within the continental United States. He also expressed very real fear that he would not be good enough to complete the O.C.S. course and obtain a commission in the United States. He did not think that after his experiences he could ever function as an enlisted man again if he failed. He also doubted his ability to take orders or to accept direction. At the same time he did not feel that he could make the decision to request release from O.C.S., because it meant so much to him to succeed.

The condition that made him sure that he could not function in O.C.S. was his inability to concentrate and to grasp the material that was presented to him in the enlisted man's preparatory school. Every move, every noise or sound he heard he associated with his combat experience. He would become extremely tense and could not

control himself. It was at these times that crying afforded some release.

He stated that he ate very little and usually could not retain anything but coffee in his stomach. He usually vomited after eating solid foods. He stated further that he slept very little because of his sensitivity to sound and his inability to relax. He smoked almost continuously and had difficulty in sleeping more than an hour at a time.

The soldier was very much concerned over the possibility of being hospitalized because of the length of time he had spent in hospitals abroad. He felt that hospitalization might result in his "going crazy." He was generally worried about his mental condition and was very fearful of a breakdown. He commented that his fear of mental illness was related to an attitude that he had heard expressed abroad toward neuropsychiatric casualties, who were said to "lack moral fiber."

Throughout the discussion there were many indications of his real doubt about himself and his abilities and of his drive to prove that he was "as good as the next." At the same time he gave every indication of being seriously disturbed and not able to meet the everyday demands being made upon him. In this condition it was obvious that he could not meet the requirements for further military service.

Psychiatric examination indicated that the soldier was preoccupied with his combat experience to such an extent that it had practically blotted out his entire civilian experience. There was evidence of overwhelming anxiety, extreme fears, and tension related to battle experience. It was felt that he was unable to react normally to his present environment in the light of these preoccupations. He was seen as being very much upset and suffering from deep-seated anxieties.

This twenty-four-year-old had enlisted through Canada, and later, upon this country's entry into the war, had been transferred to the A.A.F. He had been overseas some three years and was returning to pursue a course of instruction that would eventually lead to his obtaining a commission. When first seen in a routine "screening" process, there was evidence that indicated a need for further evaluation, and he was seen at the unit for further work-up.

As he was able to relate to the military psychiatric social worker, he began to discuss his problems and their relationship to his military future. Throughout the interview he was able to accept the fact that he was ill and recognized the need for further medical care. From the attitude of the social worker he realized that the army regarded him as ill and was prepared to assume a responsibility for helping him. He was enabled to participate in the decision as to his hospitalization; his withdrawal from O.C.S. was not a further traumatizing experience; and his subsequent discharge was effected with the knowledge that his contribution to the war effort was recognized and that his continued rôle could take a form other than that of a soldier.

When the question of discharge comes up, special consideration should be given to the clinical picture of the returned combat veteran. As already noted, these men often suffer a great deal and their symptoms may be so acute that con-

tinuation in the service may seem completely out of the question. Study of such cases in the light of experience, however, very often reveals a good prognosis and an excellent readjustment to military service. There is much evidence that many of these acute neurotic breakdowns occurred in battle in soldiers who previously had been able to render excellent military service and who made good adjustments as civilians.

It should not be inferred from this that these are all soldiers who were completely free from neurotic behavior, but they did as a whole carry their civilian responsibilities well; many were married, had held jobs for long periods, and generally were average citizens who had found a socially and personally satisfactory level of adjustment. We are not to be understood as saying that these individuals had been free from any neurotic traits. But we do feel that the majority were not more neurotic than the average "well-adjusted" civilian.

The clinical picture presented in many of the acute battle reactions includes such symptoms as battle dreams, noise startle, tremors, restlessness, inability to sleep, conversion symptoms, and others that can be considered as protective reactions developed by the soldier unconsciously as a barrier between himself and further exposure to extreme personal danger. The motivations and psychodynamics are unconscious, and the majority of such reactions conform basically to familiar neurotic symptoms. They differ in degree, and often are seen in acute forms that may be misleading. On the basis of outward and visible manifestations, their severity may easily seem to indicate a negative prognosis.

Various observers in the field have for some time noted the fact that speed of recovery often varies inversely with the distance the soldier is removed from the scene of combat. If such patients can be kept at forward stations and given treatment immediately, it has been demonstrated that their chances for rapid recovery are much greater than when they are evacuated to rear echelon hospitals. We mention this here because it sheds some light upon treatment of the neuropsychiatric battle casualty—treatment for which the military psychiatric social worker may be partially responsible—in installations removed from combat zones.

It may be laid down as a principle, to be applied wherever the military psychiatric social worker brings his skills into play, that the neuropsychiatric battle casualty suffers first of all from a tremendous sense of personal defeat. He has been separated from his unit; he feels that he has let his friends down; and he has a sense of guilt toward those who were killed, in that he himself is alive, removed from danger. Above all, he has lost confidence in himself. This would seem to be so natural as not to require comment. However, it is a force that, although expressed negatively, gives the military psychiatric social worker one of the strongest dynamic elements in the helping process.

The conflict of the neuropsychiatric casualty might be formulated as follows: Anxiety and symptom formation began when his limits of danger tolerance were passed. Old symptoms and tendencies may have come into play, new ones may have developed. He suddenly finds himself cut off from the job of war in which he has been engaged for months or even years. He is in a hospital and may go to other hospitals to be examined and reëxamined. He knows that he is a "neuropsychiatric case," but usually has very little understanding of what actually happened to him. In addition to his symptoms, he suffers from a fear that no one will believe he is ill. He wants to be well and states that he is waiting for a cure or for effective treatment, so that he can return to duty. If his symptoms have continued for some time, with prolonged hospitalization, he begins to feel that the only solution for his problem is discharge from the service. He may become very opinionated on this question. However, the desire to get well is always there in the background, unless one is dealing with a very ill person.

Recovery is achieved when the symptom has lost its protective value. In the army the neurotic has much need for his illness; life itself may hang in the balance. The symptoms, therefore, will usually persist as long as there are insufficient personality resources to meet the reality to which the soldier is or may be exposed. In simple terms, it is somewhat like this: If the soldier gets well, he will go back to duty, and may be exposed to the same threats and danger to which he succumbed before. Thus there is

resistance to help, since it seems likely to lead to a repetition of disaster.

This formation of personality drives is the negative side of an ambivalent struggle. The soldier seldom considers himself an invalid for life, although he does feel that he is of "no use to the army." There is resistance to anything that has even the slightest association with, or that is in any way a repetition of, a past trauma. If the military psychiatric social worker has an appreciation of these dynamics, which are present in every case, he will have a basis for the treatment process that will ultimately lead to a well-founded decision either to discharge the soldier or to return him to duty.

If one proceeds on the belief that the soldier wants to get well, then the case-work service becomes a search for the activities and conditions of work under which he can perform, rather than an unrelated inquiry into his personality structure from the point of view of his illness *per se,* which might result in a vicious circle of discussion about what he cannot do. About this, one may be sure, he will be very outspoken.

Another difficult factor to work with in these cases, when they reach the point of return to duty, is the mixed feeling that they have about it. It is unlikely that this ambivalence can be completely resolved, but the element of resistance in the reservation should be understood as representing the soldier's protection in the event that he is not able to meet the requirements of duty. This is another reason why the decision of discharge or return to duty is difficult.

There are other aids that have proven invaluable in this treatment approach. The trial-of-duty principle is especially applicable, since it gives a realistic basis for the evaluation of a soldier's ability to perform in a duty status. Almost every soldier has a strong desire to be well; the greatest problem is that of getting started. Even with assurances as to his ability to hold an assignment, the soldier will show a lack of confidence. Follow-up studies, however, have shown that almost all such soldiers who were returned to duty, when they were assigned as recommended, were able to continue in a military service. This was true in many

cases in which the prognosis, based upon the general symptom picture at the time of initial evaluation, may have seemed very poor.

This leads to the important conclusion that return to duty, or reëntrance into a specific job responsibility, itself becomes a therapeutic experience. There seems to be a correlation here with the fact that the earlier a soldier rejoins his unit after breakdown, the better are his chances for being returned at all. Once he is returned to duty from a neuropsychiatric rehabilitation center or convalescent hospital, he is given the first real opportunity to test himself against his greatest fear—that he is of no value, not only to the army, but even to himself. Finding that he can perform a useful day's work at a job that he has had a responsible part in selecting, he loses this fear. His ability is recognized and he has the satisfaction that comes from performing a job.

Return to duty should not be interpreted as meaning that the soldier is cured, or that his symptoms have entirely disappeared. It is a well known fact, however, that many neuropsychiatric casualties, as soon as they begin working at a job that they are capable of doing, show a marked improvement. This leads also to the conclusion that most psychoneurotics who are not so severely ill as to require hospitalization can be immeasurably benefited by being out of a hospital setting and under a program that is designed to meet their individual needs. This is evident in the army's reconditioning policy.

For the military psychiatric social worker who has a practical job responsibility, these are some of the factors that form the basis upon which he gives his service. He must have an understanding of the "culture" of the soldier and of his particular problem. Upon this understanding, he can build his service. The service may be his recommendation to the psychiatrist, and through him to the army, that the best interests of the service and of the soldier would be met through the initiation of discharge proceedings. This decision, however, usually cannot be made with reasonable certainty without the aid of a program that gives the individual's personality strengths and weaknesses an opportunity for expression under therapeutic conditions.

THE PROGRAM

The term program, as used here, may be defined as the activity engaged in by the soldier that either is a part of his everyday training and job assignment or has been set up for the purpose of meeting his needs. In a replacement or unit training center, for example, his program consists of his classes, his duty assignments, his training missions, and so on. In an installation in which the objective is to meet certain of his problems that interfere with his ability to perform duty, daily activities are planned in accord with this purpose. For the neuropsychiatric patient, such a program would include job-hobbies, recreation, physical training, education, orientation, and other activities.

In both instances, in a duty organization or in a treatment center, it is the activity in which the soldier participates that is, for him and for the military psychiatric social worker, the gauge of his adjustment. It is upon this performance in a here-and-now situation that the social worker bases his evaluation. It provides him with countless opportunities within army limits to use change—such as change in assignment, job, or selection of activity, sports, job-hobby interests, and other measures—in a constructive way.

Herein lies the military psychiatric social worker's most valuable case-work tool, the army's definition of his position in relation to the patient. When a soldier is unable to adjust in a line outfit, the army creates a problem for him. The social worker helps him adjust to his job through a process of clarification. In this process the social worker indicates where the soldier stands, what the army expects of him, and what his difficulty is in relation to army requirements. If the situation warrants it, the social worker can help through adjustments within the army structure, and in accordance with directives for this purpose, that will make for a change in which the soldier may continue to be of service in an area in which his potential emotional problems will be less likely to be reactivated.

In so far as programs in neuropsychiatric reconditioning centers and convalescent hospitals are concerned, the activities available are all important for the military psychiatric

social worker as a field of operations. Since it is the mission of such an installation to return to duty as many patients as possible, or to aid them toward a constructive separation from the army, such programs have been developed with a twofold focus. A soldier who engages in auto mechanics or clerical administrative work because this is his interest can do so with benefit whether he is to be discharged or returned to duty. If he shows himself as a potentially capable auto mechanic, and if his illness does not interfere with his job during rehabilitation, then this is a sound basis for recommending his assignment to work of the same type in the army. With this emphasis in an activity program both the army and the soldier will have gained from the experience. If the soldier is discharged, he will have had an experience that will help him to reorient himself as a civilian. Inability to perform a job in the army by no means implies a civilian disability in this or another job.

The military psychiatric social worker has a further service to offer in the planning and execution of such a program. The program of activities for neuropsychiatric patients, for example, requires a great deal of supervision if a large measure of its treatment value is not to be dissipated—that is, from a psychiatric point of view. The treatment responsibility is that of the psychiatrist, but in his liaison rôle between psychiatrist and program instructors, the military psychiatric social worker can engage in group therapy, observe the patients during activities, and utilize all of this information in individual interviews.

LIMITS OF CONTENT

Wherever social workers deal with the problems of an individual, the questions of what and how much arise. For the military psychiatric social worker these are always important considerations. Perhaps some of the impetus toward focus came from the need to deal with relatively large numbers of men in a limited time. This has resulted in benefits that have favorably affected the quality of the work and have brought about in many military psychiatric social workers an increase of skill in the use of their basic professional techniques.

It is much more important to focus upon what will help a soldier meet the requirements of the army than it is to attempt to help him with the personal implications of his problem when this involves a basic change in his personality make-up. The military psychiatric social worker is no more equipped to cure a neurosis in the army than he would be to engage in psychotherapy as a civilian.

Military psychiatric case-work service is a skill in which an understanding of the dynamics of relationship is brought into play in giving a specific service that is designed to help a soldier meet the requirements of the army. Understanding of the nature of the soldier's neurosis, and how it affects the quality of his military service, is of prime importance. The soldier will not be helped to resolve his neurotic traits without intensive psychotherapy, but he can be helped to use his potentialities if he is helped to relate them successfully to the army.

The military psychiatric social worker's job is primarily one of finding the strength of the soldier who has been unable to cope with a specific army responsibility. Then, through use of the authority delegated to the unit he represents, services are made available to the soldier and an opportunity is given him to use his capabilities where they will meet army requirements. Authority in this sense can become a source of strength upon which both the social worker and the soldier can draw as need is evidenced in their changing relationship.

This limits the content of the social worker's job to what is most likely to help both the soldier and the army. It saves him from getting lost in the details of a psychological symptom picture beyond the point where a direct cause-and-effect relationship to the army problem can be maintained. A soldier may be "nervous" and may have had neurotic tendencies all his life. This is not significant as long as he can perform well enough for his own and the army's satisfaction. There are persons in all walks of life, who, though they have neurotic traits, are relatively well oriented to reality and can maintain a place as responsible members of society.

This does not, however, minimize the military psychiatric

social worker's job of finding the strength and understanding the weakness of the individual who has suffered a real personal defeat through breakdown. This involves the foundation of the individual's personality structure and requires at every step a clear understanding of the army and of the individual's relationship to it. In the military psychiatric social worker-soldier relationship, while it is far more important to dwell on what the soldier is able to do than to become involved in endless details of his illness and deficiencies, some release of his feelings to the social worker will have therapeutic value when related to decisions in which they are both concerned.

This in no way limits the social worker's total responsibilities for helping the soldier. There is no responsibility more crucial than that of contributing toward a recommendation for discharge or for duty. With reference to limited content, it should also be mentioned that the military psychiatric social worker usually starts his job with a diagnosis—medical or psychiatric—in available military records. He has no responsibility for making the diagnosis. This is the medical officer's job. Thus, the social worker is relieved of concern as to the nature of the diagnosis. He is bound to accept it and begins with the assumption that it is correct in a medical, psychiatric sense. He concerns himself with the way in which the soldier's personality difficulties interfere with his army adjustment, and with what can be done to help him.

A WORKING CONCEPT OF PERSONALITY INTERACTION

The concept of total personality is one that encompasses both human strengths and human weaknesses, both the assets and the liabilities of the individual. Personality is the product of the individual's physical and intellectual endowment as it has developed or been inhibited through his life experiences. It involves the extent and limits of his physical endurance, his ability to meet pressure without, or in spite of, emotional upset, as well as his education, his vocational training, and his technical skills. It involves his attitudes, his ability to tolerate frustration, his reaction in the face of competition, and the determination with which he meets new

situations or attempts to solve problems with which he is confronted. It reflects his cultural background, the tastes he has developed, and his general adaptability to other cultures in his adjustment to army life.

These factors are all related to the requirements of the army. A man's physical condition is of essential importance to the performance of his duty; it is a determining factor when it comes to deciding whether he is to be assigned to the paratroops or as a company clerk in the Zone of the Interior. Upon his intellectual potentiality depends the decision whether he will be trained for a job as high-speed radio operator or as a basic laborer. His emotional maturity is the yardstick against which will be measured the degree of responsibility he will be expected to discharge or the manner in which he will be able to make an adaptation to army life.

These complex factors and their interrelationship are the material with which the military psychiatric social worker deals. The general adjustment, or lack of it, of a soldier is a reflection of these personality strengths and weaknesses. The division of the personality into conceptual segments of mental, physical, and emotional components determines the area in which each of the several professions concerned with the human personality exercises its function. The psychologist is trained to evaluate the potential intellectual ability and aptitudes of the individual; the medical practitioner determines the degree of organic involvement; and the psychiatrist, through his specialization, assumes final responsibility, coördinating the knowledge that he has of the soldier's emotional life with that contributed by the psychologist and the medical practitioner. The psychiatric social worker, under the supervision of the psychiatrist and by reason of his professional training, coördinates the findings of the other specialists as they relate to the individual's problem and, through the techniques of the interview, helps the individual to a solution of his problem.

The social worker is always aware that an individual's behavior is symptomatic of very complex and frequently unconscious motivation. He also recognizes that the solution of behavior problems, if they are reflective of basic emotional pathology, can be attained only through extended and very

specialized psychiatric treatment. Understanding this fact, the social worker confines himself to the limits of his own technical equipment. His function becomes one of helping the soldier adjust to the environment of the army through assistance in the solution of the problems that army life has created for him. In this service can be found the basic elements that lead to mental health.

RECORDING

Orientation is the keynote of all army recorded material. There is good reason for this. It contributes to clarity, to time saving, and to ease of understanding. It saves the lay reader for whom it is intended from becoming confused in details that have no direct bearing on the situation, and possibly overlooking the main point that is of concern to him.

Various army functions require different types of recording, each being standardized to meet the purpose for which it is intended. Furthermore, it should be noted that the army functions through written orders. The military psychiatric social worker in a clinical setting may have any number of different types of written material to submit. The variations will depend in each case upon how the unit to which he is assigned translates its function into action. In a replacement training center, an inter-office memorandum ("buck-slip") may be used. In a hospital or a reconditioning center, the various medical-corps forms may be used to record information and transmit recommendations.

The military psychiatric social worker may very seldom sign any such material, since it is always submitted over the signature of the officer in charge, who is responsible for the decisions of his section. The social worker may, however, be called upon to submit the report to the psychiatrist and it may either be incorporated with collateral findings or be accepted as the final report.

In the military psychiatric social worker's job there are several basic forms for recording material, depending upon the use for which they are intended. One of the longest reports generally used would be material prepared for presentation to a discharge board or a courts-martial board. The following is an example of recording in a recommendation

to a discharge board. Depending upon the requirements of the board, the material may require varying kinds of emphasis. In all cases, especially in a case report recommending discharge or any other action, the reasons for the conclusion must be incontrovertible and sufficient evidence must be given to substantiate them.

Case I

Summary of Evaluations

1. This thirty-six-year-old enlisted man was referred to the mental-hygiene division by the courts and boards section for an evaluation of his personality and his suitability for retention in the service.

2. The dispensary surgeon reports that the man has no physical defects that would warrant consideration of separation from the service via AR 615–361.

3. This soldier, of superior (Class I) intelligence, was born in ..... His father, who is eighty-one years of age, lives in ..... He is said to be a coal miner who drank quite a bit in his younger days, but who now boasts that he has not taken a drink since he was thirty-three years of age, when he became very active in church affairs and developed into a well-respected man in the community. The soldier's mother, who died eight years ago at the age of sixty-three, is described as a very conforming person who was active in community affairs.

The soldier is the fourth of seven children and indicates that, as a youngster, he was "more or less a fair-haired boy." He also sees himself as having been "wayward." He "had a desire to take things," and engaged in petty thievery from stores or took things from his own home. He comments that he "didn't have any use for" the things he took; it was "for the thrill of being able to steal."

He claims he was never arrested for these acts and "nearly always hid the stuff, except the money," which he used to satisfy his desire to play slot machines. He cites an instance in which he short-changed his mother $5.00 on money he secured from the bank, and felt "badly" when she found out about it and punished him by depriving him of certain privileges.

When he was fourteen, he ran away from home with another boy because "we thought we were being treated badly by our parents." They went to Kansas City on a freight train, but after being there for a day became "scared and hungry" and returned home.

The soldier indicates that he always did very well in school without having to work much, and as a student in high school, he spent a good deal of time around pool halls, gambling.

He was the only one of the children who "was given the opportunity to go to college." He went to ..... Teachers College for two years, but left at the end of that time—although he claims to have been doing very well in his studies—"to make money."

For about a year he worked around home, driving a truck and working in a machine shop, and then went to ....., where he secured a job which he held from November until April, 1930, when he was fired after an argument with a department head. He was unable to find

work and returned to ....., where he did odd jobs until October, 1930.

He had "become very much attached" to a girl in ..... and when he could not find work, he became "disgusted." The girl proposed a year's trial separation to see whether or not they really cared enough for each other to be married, and in December, 1930, he enlisted in the army. In June, 1931, she joined him and they were married. He states that he had a fourth-class specialist rating in the .....Corps and was stationed at .....

A son was born to him in 1933 and he dates the beginning of his difficulties at about this time. He had been introduced into running a "black-jack" game, and this caused him to lose sleep. Prior to this time, he had never been more than a convivial drinker, according to his story, but he now began to drink steadily "to keep me going." He comments: "The more I drank, the more I wanted, and like any other drunkard, the habit grew."

He was discharged from the army in 1935. Prior to that time, his game had been abruptly stopped by a post order. He explains that while he was running it, he never gambled himself, but as soon as he stopped, he began to gamble himself.

He remained with his wife until she finally divorced him in 1938—"she didn't like my drinking." He describes this period as one in which he could not keep a job "although most employers gave me three or four chances." He gambled and drank throughout this period, and he explains that his wife went to work "to make extra money at first, but wound up supporting three people." He kept his jobs anywhere from a week to two months before he was fired, and was never sober more than "long enough to get a job."

He describes his life since 1938 as having been "one nightmare of drinking." He indicates that he is not "interested in anything." He drifted about the country securing jobs as a cook ("it is just an easy way to get a job"). His travels took him mostly through the West and Southwest.

He was arrested about eight times, the first of which was in ....., in 1936, when he was drunk and disorderly. He was arrested in ..... four times in all, for the same offense, but was released after paying a fine. He was also arrested in 1939 for drunken driving, and in ..... in 1940.

The only sentence he admits to having served is that of fifteen days of a thirty-day sentence in ....., in 1941, when he was charged with being drunk, disturbing the peace, and destroying property in a hotel. He states that when he drinks he is an entirely different person. Usually, he becomes "mean and sarcastic." During the last ten years, he says, "I have not been much use to myself or any one else all through the use of alcohol."

Since his induction in October, 1942, the service record reveals that he has been AWOL on twelve occasions for a total of forty-three days, and has been in confinement about two hundred and twenty days. He describes his most recent confinement as "about the happiest time of my life." He states that he is "almost sorry I am out of confinement." He had "hoped that confinement would get me away from it, but since I am out, I have the same old feeling to get out because I have to have a drink."

4. The developmental history here is clearly indicative of the elements of psychopathology that later on became fixed in dependence on the use of alcohol, as the environmental pressure became such as his personality resources could not withstand. The compulsive elements of his personality pattern are clearly seen in his early stealing activities, the subsequent gambling, and the later use of intoxicants, to which he apparently has become habituated. The feeling of emotional deprivation is also expressed in his early parental relationships, and self-destructive drives are equally evidenced in his continuing pattern of adjustment.

His condition at the present state of his adjustment is one that would offer a poor prognosis even under prolonged and intensive psychiatric treatment, which is not available within the army setting. In view of these factors, he shows no potentiality for responsible military service. He is not psychotic (insane) at the present time and is considered legally responsible for his actions, but his habits and traits of character render him unsuitable for military service. It is, therefore, recommended that he be separated therefrom via AR 615–368.

Essentially the same purpose can be achieved without loss of relative content in the following type of presentation in a recommendation for return to duty. In both cases it will be seen how all content is focused upon answering the reason for the disposition.

Case II

Presenting Problems.—The soldier was first hospitalized at the ..... Evacuation Hospital on ..... November, ... He was transferred to the ..... General Hospital on ..... November, with the transfer diagnosis of psychoneurosis, hysteria. A board of medical officers found a deviation of the nasal septum and recommended transfer to another general hospital for further hospitalization. He was admitted to the ..... Station Hospital on ..... December, ..., with the diagnosis of psychoneurosis, reactive depression. A medical board, on ..... January, ..., at that hospital recommended transfer to the Zone of the Interior, with the diagnosis of psychoneurosis, reactive depression, severe, aggravated by combat. He was returned to the United States and admitted to the ..... General Hospital via transfer from ..... on ..... April, ... He was transferred to the mental-hygiene unit on ..... May, with the transfer diagnosis of psychoneurosis, reactive depression, mild.

Military History.—The soldier was inducted on ..... February, 19..., from ..... After four days at Camp ....., he was transferred to Camp ....., where he underwent basic infantry training for fourteen weeks, receiving an SSN of 745—(rifleman) on ..... October, ... He became a member of the ..... infantry, which remained at ..... Camp from July, ..., after having been at Camp ....., until February, ... During this time he had been assigned as a cook's helper. In February, ..., the organization was transferred to Camp ..... and became part of the ..... Division, which left for overseas duty on ..... June, ... The soldier participated in the invasion of Sicily and continued through-

out that successful campaign. His organization then landed at ..... Beach in September, and he remained with them until November, ..., when they were ..... miles south of .....

Personal History.—The soldier was born in ....., New York, on ..... February, ... He was the oldest of six children. The father has been an employee of the ..... Department for many years, and is said to be a very intelligent and able man, with an even disposition. The mother is described as a "very nervous" woman who "worries about everything." She is reported to have been under a doctor's care for many years. According to the soldier, he contracted the usual childhood diseases, but was considered a relatively healthy child.

He attended parochial school from the age of six to the age of fifteen. He was extremely interested in academic work and was considered a "very active child." He was an excellent student and received a scholarship in a parochial high school. He constantly "worried about not being at the head of the class." This resulted in a "nervous breakdown" at the end of his first year of high school. The cause was given as "overstudy." He was withdrawn from school at that time and after resting for several months, he secured a position with ..... concern, first as a mail clerk, then as a general clerk, later as a telephone operator, and finally as a bookkeeper.

He remained at this job for about two years and then found the work too "nerve-racking" and finally had to give it up. He went into partnership with another man and has been a part owner of a ..... shop for the last ten years. This was his occupation at the time of his induction.

Present Situation.—The soldier talks quite easily of his breakdown in combat. ("I went crazy I guess.") He states that in the long exposure to combat he had seen many of his very close friends killed and finally "went off my nut." He sees himself as having become increasingly better since his return to the States. He has been very actively oriented toward return to duty and hopes to be made an instructor or a mess sergeant. He feels that he has done his work for a long time under all manner of conditions and that he is competent in the job. Another incentive for his seeking advancement is the fact that he has completed elaborate arrangements for his marriage, which is to take place on ..... June, ... He is anxious to return to duty so that he can find out what is expected of him and rearrange his personal affairs with the army's requirements.

During his stay in the ....., he has participated very well in the program and has maintained a consistent and healthy attitude toward return to duty. He is very much involved in preparation for his forthcoming marriage and plans to make his furlough his honeymoon period.

Recommendations:

1. This soldier's background and history reveal a personality structure with a strong anxiety base. There are many evidences of healthy and positive aspects which are evidentally channelized in the strong drive for achievement that the soldier has always shown. His attitudes are socially very well oriented.

2. He has sufficiently recovered from a reactive depression—precipi-

tated by long exposure under very severe combat conditions—for a trial of duty.

3. With the soldier's present incentive and attitudes, return to duty is indicated, with the recommended assignment of cook (SSn.060).

The following case illustrates many of the elements of the philosophy of the treatment process, with the relationship of the case-work-group-therapy program evident by implication. The recording indicates that the problem of the soldier's future army adjustment is the need for vocational opportunity, which he later received. His ambivalent attitude toward return to duty is seen in his resistance to garrison life. The family background and clinical picture, as well as the soldier's social and military adjustment, are all taken into account in the decision to recommend his return to duty.

Case III

Presenting Problem.—This soldier was first admitted to the ..... Field Hospital on ..... January, and sent to the ..... General Hospital, after appearing crying, shaking, and panicky. After three days he was transferred to the ..... Replacement Depot and was given a limited-duty assignment. While there his condition continued to be severe and he was readmitted to the ..... Station Hospital on ....., with admission diagnosis of "exhaustion." He was transferred to the ..... General Hospital on ..... February, with the transfer diagnosis of "psychoneurosis, anxiety state, chronic, with acute exacerbation due to combat." He was boarded on ..... March and ordered returned to the Zone of the Interior with the transfer diagnosis of "anxiety state with depression, severe, chronic, recurrent." The soldier was admitted to the ..... General Hospital on formal transfer from ....., on ..... April, and was admitted to the Reconditioning Facility on ..... May, with the same diagnosis.

Social History.—The soldier was born in ....., ... March, ... He is the youngest of three children, having an older full sister and a half sister considerably older, the child of his mother's first marriage. His father, who died recently, is said to have been a chronic alcoholic who had been in and out of the home since the soldier was about ten years of age. His mother died in 1938. She had always had to work very hard doing washing and housework because of the father's alcoholism. She had not been a well woman, having had high blood pressure and "bad nerves, too." She was under a doctor's care and was finally admitted to the ..... State Hospital in March of 19..., dying there in June.

The soldier describes himself as having been a delicate, sickly child because of several illnesses, including "influenza croup" at the age of three, intestinal grippe, and the various childhood diseases. He always contracted colds and was considered delicate. He was a tense

and unhappy child, a chronic nail-biter. He recalls taking vitamins and minerals. This sickly period continued until he was about fourteen, after which age he became very tall, broad-shouldered, and well-built.

He worked and helped the family as well as he could with odd jobs, finally leaving the eleventh grade at the age of eighteen to take a full-time job in a grocery chain store. He was a member of the National Guard and spent his vacations in camp. As he got older, he was able to assume more responsibility and felt very close to his mother and his sisters. There is apparently a strong relationship still between him and his sisters. He expresses his hostility for his father quite freely and bitterly, especially in connection with the fact that his father was drunk and did not appear at his mother's funeral.

The soldier was activated on ..... January, 19..., with his National Guard outfit, and later became a telephone linesman with the ..... Field Artillery Battalion. He has always enjoyed the army and feels that he has been a good soldier. About three years ago, he was in a car smash-up in which his buddy was killed, and the emotional effects of this trauma resulted in his becoming extremely worried. He recalls a period of dreams relating to this accident. He was sent overseas on ..... August, ..., and went into action on the ..... front on ..... October. He had been in action about ninety days at the time of his first admission. He felt that he was able to do his job well until the precipitating incident, when he was pinned down by an artillery barrage in a bridge culvert. With the shells bursting all around him and "my buddies being knocked off," he become very shaky and tremulous, and started to cry. It was after this that he was admitted to the field hospital.

Present Situation.—The soldier feels that he has continued to improve, although he has occasional battle dreams which leave him with a feeling of fatigue and of weakness in his legs, and he "worries about the least little thing." He talks very freely and easily about his experience and is able to focus constructively on plans for his return to duty as well as his eventual return to civilian life. He recognizes his inability to face combat again without equivocation. He feels that he would have a great deal of difficulty in being a garrison soldier and performing routinized activity such as drilling, marching, and so on. He feels he has done all that kind of "soldiering" that he can stand. He is interested in further military service, but feels that he should have an opportunity to take specialized training, to fit him for a job in the army as well as for his return to civilian life. He is very much interested in mechanics and in the group program here; has participated in a very positive fashion, showing sustained interest, activity, and ability.

Recommendations:

1. This soldier has shown considerable personality strength in his recovery from a severe anxiety reaction precipitated by his combat experience.

2. His background and history reveal adequate basis for a neurotic personality structure, but he has evidently been able to channelize his assets into a satisfactory civilian adjustment.

3. There are indications of residual and latent anxiety which apparently motivated him in a positive direction in his strongly expressed desire for trade training.

4. It is recommended that this soldier be reassigned to a replacement training center or to an installation in which he can receive on-the-job training in a mechanical field for which he has shown aptitude.

The following are samples of briefer reports used in installations in which the military psychiatric social worker may be assigned to a unit with responsibility to a line organization. Here the informal inter-office communication ("buck-slip") through prescribed military channels is adequate to meet the need of the situation. Within the unit, the record of its activity, and brief notes sufficient to give a thumbnail sketch of the process whereby the decision arrived at in the "buck-slip" was made, can be retained on file for reference. In these brief reports there is also evidence of the process by which the unit arrives at its decision in making its disposition of a case. Not to be overlooked is the interpretative value inherent in such a report.

Case I

1 Director, Mental- Hygiene Unit	1. S-1 2. Class. O.	1. This enlisted man, aged nineteen, of dull intelligence (group IV), was interviewed at Chauffeur School and found acceptable for assignment there. 2. He has been attending Wire Line Section, but is not making satisfactory progress and the officer in charge requests that he be relieved. The soldier had about a year's experience in civilian life as a truck driver and is interested in this type of assignment. 3. Relief from Wire Line Section of the Signal Communications Division and assignment to Truck Driver's Section of the Motor Vehicle Division is advisable for this soldier. 4. He will be followed by the mental-hygiene unit in his adjustment to the new assignment. Director, M.H.U.

Case II

Class. O.	Dir. M.H.U.	Reclassification Case 1. Request that the below named man be relieved of his present assignment and returned to his base. Soldier failed R.O. and tried W.L., but could not make the grade. (soldier's name) (Class. Officer

2	1. S-1	1. This nineteen-year-old soldier was referred to the mental-hygiene unit by Classification because of failure in Radio Operator School and in Wire Line School.
Director, Mental-Hygiene Unit	2. Class. O.	2. He was found to be unsuited for training as a radio operator because of a low R.O.A. score (Group IV), and his frustration at being unable to learn the code. He was reclassified to Wire Line School, but fell from the pole, claiming weakness of the left ankle; this is being checked up. This school requested his reclassification.
		3. The C.S.D. has found him suitable for assignment to Supply Clerk School. He scored 100 (Group III) on the clerical-aptitude test. Transfer to Supply Clerk is requested, effective by ..... Director, M.H.U.

Case III

From: Mental-Hygiene Unit	To: 1. Adjutant 2. C.O.	1. Soldier, nineteen years of age and of average intelligence, was referred for being AWOL from ..... to .....
		2. He left the camp area after bed check to go to a neighboring town and under the influence of liquor left, and visited ..... to see friends. He stayed a day and returned when he recognized the seriousness of his offense.
		3. In his military life in camp, soldier has gotten along well and is quite satisfied. However, he failed at Radio Repair Course and is now having considerable difficulty in Fixed Station Operator Course, ..., to which he has been assigned. He does not like to admit failure and has not complained.
		4. Soldier's civilian life is characterized to some degree by immaturity and impulsiveness. Soldier's adjustment to the army has been complicated by personal problems which he is still working through.
		5. Soldier shows potentialities for military service.
		6. Disciplinary action may have a salutary effect.
		7. His adjustment is being followed by the unit. Psychiatrist

Case IV

1. S-1
2. Class. O.

1. Pvt. ....., aged twenty, of superior intelligence (Group II), was referred by Medical Officer, Infirmary No. ..... because of headaches. Soldier is assigned to Radio Operator School, and the strain of taking code seems to have brought on the headaches. He has certain nervous traits which are being studied further, and which contraindicate continuation in R.O. School.

2. Soldier is a high-school graduate, and has superior clerical aptitude. His qualifications were reviewed by Message Center School and he was found to have the requirements for admission there.

3. Request that soldier be relieved from Radio Operator School and reassigned to Message Center School, effective ..... October, ...

Score to be noted on Form 20 card:
Army Clerical Aptitude Test—Scores 125 (Group II).
Director, M.H.U.

The manner in which the military psychiatric social worker uses recording reflects some of the differences between civilian and military case-work practice. The military psychiatric social worker gears recording, like every other element of his professional skill, to the needs and requirements of the installation. Recording of a symptom picture on a tag in a company aid station may have current and long-range value, and a simple one-sentence "buck-slip," requesting a reassignment, may have far-reaching effects on the future army and civilian adjustment of a soldier. The elements involved are the same as in the cases cited here. How does the recording help the army and the soldier to be more effective? It embodies the degree of responsibility that the unit has carried in the case and indicates in a measure its continuing responsibility.

CONCLUSIONS

The generic implications of social case-work, as presented here, are yet to be completely digested. Some specific indicators can, however, be appraised. The army has presented a complex structural organization to which the professional discipline of social work has adapted itself. In so doing, social work has not only demonstrated its ability to meet the requirements of the army, but has, in that process, acquired an experience of immeasurable value.

The definite nature of the needs of the army determines the function of the social worker, limits the scope of the case-work relationship, and gives it purpose of a sharply defined character. Rarely in civilian life will an agency have a function as clearly defined as in an army directive. These factors give the case-work process strength and quality.

In such a setting, it is of vital importance that both the social worker and his soldier client be fully aware of the reason for their contact. The social worker particularly must understand his own rôle in relation to his client's difficulties. He must have an acute sensitivity to personality reactions, to help him in determining the degree to which some of the client's difficulties are reactions to the reality situation. If the problem is symptomatic of a more complicated personality involvement, requiring either technical equipment beyond his own or a setting that is not permitted to him by reason of his defined job, then he must be able to accept the limitation of his service. This will inevitably cause conflicts for the case-worker until he has arrived at a thorough understanding of the services of his agency and can accept the client's problem. At that point the helping process attains its maximum effectiveness.

Case-work treatment in the army, therefore, is directed toward the solution of the soldier's problem in relation to his army adjustment, as reflected by the degree to which he can relate constructively to the military psychiatric social worker and use the services that the army makes available to him through this medium.

As a result of this meeting, both the individual and the army benefit. The soldier who is helped to a better army adjustment becomes a more effective person and the army gains a better soldier. If, as an outgrowth of the case-work relationship, the soldier's problem is found to be such that it cannot be handled within the army, and if at the same time it renders him ineffective as a soldier, separation proceedings can be effected through channels. In this way the soldier is removed from a reality that it is beyond his capacity to meet and the army separates from itself an ineffective

soldier who may still be able to contribute to the war effort as a civilian.

These results cannot be measured or defined by the length of the case contact or the quantity of the material covered. The degree to which a soldier's problem is soluble through the specific services made available to him will determine the effectiveness of this treatment process.

The word "responsibility" has been used repetitiously throughout this paper, and is, therefore, deserving of some further consideration in view of the importance that is attached to its meaning. In civilian life, responsibility embodies what it is that people are expected to do. In time, as an individual grows up, he is expected to do more and more in the way of taking care of himself, and when he reaches adulthood, he may have the additional desire or obligation to take care of others. This usually includes not only providing food, shelter, and clothing, but adjusting to community standards of behavior, and pursuing a vocational or professional course of training and practice. He may become part of a political, religious, or social group, and thereupon assume certain obligations along with privileges. In all of his behavior there is a relationship between himself and those to whom he is responsible.

In the army a soldier, except under combat conditions, usually has no responsibility for securing food, shelter, and clothing. With this fundamental difference, other basic differences appear. A soldier's responsibilities become his duties; it is not a question of what people expect of him—it is, rather, what he must do in order that the mission with which he is charged may be successful. He does his job as part of a combat team. The lives of men depend on his fulfilling requirements, as his own life depends on others. His adherence to duty, multiplied by that of millions of other men, is the measure of the success or failure of the army. The importance of meeting the required standards of army performance, therefore, cannot be overemphasized. It is the responsibility of the civilian in a democracy at war.

It is obvious that the degree to which an individual has been able to meet his responsibilities as a civilian will be

one indicator of his ability to adjust to army living. In the early stages of training, an evaluation of this background is extremely useful in determining the degree to which the transition to army requirements will create problems of adjustment. As the civilian becomes a soldier, his ability to adjust to military requirements will be a much more reliable yardstick against which to measure his potential adjustment. Similarly in the case-work relationship, the manner in which the soldier is able to assume a participating rôle in the solution of his problem will be an index of his personality resources. As he participates in the selection of the services available, and as he shows ability to accept limitations or to make choices, further progress will be noted. The manner in which he meets a reality test always mirrors the degree of his maturity.

Social workers in the army who have been permitted to practice their profession as part of their military duties are participating in a rare opportunity—that of bringing the practice of social work to a cross-section of the general population not usually reached in civilian life. It has extended the frontiers of social case-work beyond the services established for, and usually identified with, the ill, the underprivileged, and the delinquent elements of our country. It is reflective of the trend in social work toward services to private paying clients, and to industrial and labor organizations. It represents a service to individuals who, by the very nature of their stake in participation in securing help, will demand that more responsibility be assumed by social workers in response to more active participation on the part of the client. In this stimulus is to be found the vitality of the future of the profession.

In work with individuals who have met a reality far more demanding than that in which human personality should reasonably be expected to carry on under peace-time circumstances, the resilience and strength of human personality have been demonstrated. In the recovery of neuropsychiatric battle casualties there is ample evidence to warrant profound respect for the reservoirs of personality resources that individuals are able to call upon. In recognition of this, social

workers will further refine their techniques to increase the participation of their clients as they are able to assume new responsibilities. This presupposes an increased skill in understanding the client, and will eventually determine the degree to which social case-work achieves the goal of aiding in maturity of action.

BOOK REVIEWS

THE ATTENDANT'S GUIDE. By Edith M. Stern, in collaboration with Mary E. Corcoran. New York: The Commonwealth Fund, 1945. 104 p.

This book is a real contribution. It gives an explanation, not only of what are correct attitudes on the part of attendant toward patient, but, more important, the reasons why these attitudes must be acquired. This is done simply, but skillfully. There has been a remarkably successful avoidance of laying down "rules," and, instead, an emphasizing of the professional aspects of the intimate care of mental cases and an appeal to those humanitarian instincts or impulses that all of us have, though in varying degree. In truth Miss Stern's quotation from Luke VI, 31—"Therefore all things whatsoever ye would that men should do unto you, even so do ye also unto them"—is the underlying motif of her whole book and embraces its fundamental principle.

The book is in no sense a serman, however; there is no preaching. On the contrary, it is full of information to help the attendant in orienting himself, and of practical advice as to his duties, his relations with others, and his responsibilities and obligations.

As stated in Chapter I, the book deals with "the way to look upon your patients, the ways to take care of them, how to fit in best with the rest of the hospital staff, and how to make the most of yourself and your time." It gives the caution that rules and regulations are made by the individual hospitals and are not considered in this text. It emphasizes the fact that mental patients are *sick* and are to be so regarded as much as if suffering from some obvious physical illness. And the value of a systematic routine of work and duties is carefully explained.

The importance of the attendants' work is stressed—and properly so: "You, perhaps more than any one else, can help patients get well. You are with them constantly—days to the doctors' hours. The little things you do, week by week, day by day, hour by hour, minute by minute, can make or break them. Of all the members of the hospital staff, you are closest to the patients. You can support the work of doctors and nurses, or cancel it. . . . Yours is a great responsibility, and a great opportunity."

Subsequent chapters deal with such matters as personal attitudes toward patients, ward housekeeping, cleanliness, the grooming and

recreation of patients, the serving of food, and the attendant's relations with his associates, with visitors, with the public, and with his patients.

Part II considers the various behavior reactions of patients and particular ways of meeting the situations and conditions incident thereto. The headings of the chapters in this section are a fine example of the author's studied avoidance of psychiatric terms and use of words understandable to any one: *Patients Who Do Too Much, Patients Who Don't Do Enough, Patients Not Fit to Be Seen, Patients Who Want to Die, Old Folks.* You can't beat these for straightforward English.

It is well that attendants, at the beginning or early in their work, should not be faced with such terms as "manic," "introverted," "regressed," and so forth. It may assist them in straight thinking, observing, and reporting—duties that are well-covered in suitable chapters.

The contents of the final chapter justify its title—*Straight Talk About Your Future.* Here, as in the excellent foreword by Dr. S. W. Hamilton, the need for the establishment of well-rounded courses of instruction for attendants is pointed out. Perhaps this work is not the place to express the conviction, held by so many, that the day is at hand—in the not-distant future—when the attendant will be given the status justified by his nearness to the patient and the therapeutic opportunities presented him—a status commanding and granted respect, one of true professional dignity. This concept must be accepted if mental hospitals are to become what modern medicine demands.

Perhaps all this is implied in Miss Stern's final words: "You are in on the ground floor of a coming profession. Make the most of it."

Hospital administrators should not fail to give this book wide circulation amongst ward personnel. It is absolutely practical, thoroughly worthy from all points of view.

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THE VETERAN COMES BACK. By Willard Waller. New York: The Dryden Press, 1944. 316 p.

The Veteran Comes Back is an outstanding book by Willard Waller, World War I veteran—and assiduous student of veterans' affairs—and associate professor of sociology, Columbia University. His earlier book, on "The Family" is reported to be psychiatrically oriented and is used as a college textbook.

The Veteran Comes Back is a grim dissection of veteran psychology and a serious attempt to rectify past failures and do a good job this time for the veteran. It is written in a clear, terse, penetrating style both for the professional and for the lay reader. Certainly no psychiatrist interested in the maladjustments of veterans should fail to read this over-all presentation of the problem. The author skillfully builds up well-documented evidence for his assertions and conclusions. There is an excellent historical survey of soldier benefits since the American Revolution. The importance of veterans' organizations is stressed as well as their fundamental conservatism unless, through neglect of their disabled and needy members, they fall under the spell of political demagogues. The usual "too little and too late" policy in the rehabilitation of the veteran, Mr. Waller asserts, produced the angry, bitter reaction so well remembered in the 1932 bonus march on Washington.

The author points out that to-day's soldiers were raised during that unhappy period of economic depression. They are sick and tired of insecure, marginal living. They have fought for their flag, and that flag represents to them first a job that will insure food, shelter, and clothing, and only secondarily a political philosophy.

The author admits that he has lumped veterans together as a type, but only for purposes of exposition. Such phrases, for instance, as "the kind man pities them; the just man feels guilty toward them; the informed man fears them," are quite characteristic of his tendency to generalize freely. But toward the end of the book, he stresses the fact that each veteran must be treated as an individual or the rehabilitation procedure is bound to fail.

One does not expect a sociologist to stress the psychiatric side of rehabilitation, and yet what the author does say about the psychoneurotic and the difficulties in his treatment, due largely to the compensation factor, appears to be sound. He wisely points out that for every veteran who shows a frankly recognizable psychosis or psychoneurosis, there are many with "hidden disabilities" that need expert help as soon after discharge as possible, to prevent the development of chronic physical and mental illness, a ne'er-do-well, "the world-owes-me-a-living" complex, or actual criminality.

He warns against early stinginess toward veterans and later lavishness when pressure groups start. He convincingly points out that if three million disabled and handicapped veterans were compensated at $100 a month, it would come to $36,000,000,000 at the end of ten years and the men would still be disabled. Whereas, if early intelligent treatment and rehabilitation of these men should cost even the fantastic sum of $10,000 a man, not only would the total

sum expended be less, but in a very few years the veterans would have contributed a vastly greater sum to the national income. Efficient placement of the veteran, by means of a national job survey, proper schooling, and helping him in his personal relationships, is emphasized.

There is an excellent chapter on what the local community can do if it is well organized and led by practical men of good will in and out of veterans' organizations. The author insists that "the real work of rehabilitation must be done in the local community."

A good, painstaking screening job for the veteran disabled in mind and body should be done now by professionally trained social workers, working hand in hand with effective amateurs. These professionals must be trained at once in great numbers if effective rehabilitation of the individual veteran is to be accomplished.

In summing up, Mr. Waller states that "we must stop thinking about veterans' benefits" and begin thinking about a "veterans' program" that will be prompt and timely and that will give adequate aid once and for all.

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ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY. Edited by J. K. Hall, M.D., *et al.* New York: Columbia University Press (for the American Psychiatric Association), 1944. 649 p.

In October, 1844, the American Psychiatric Association came into being. In 1941, mindful of the imminence of the centenary of that event, the then president of the association, Dr. George H. Stevenson, of London, Canada, conceived the idea of marking the one-hundredth anniversary by preparing and publishing the story of the hundred years of psychiatry in America. The idea was at once taken up with an earnestness and a pertinacity that, judging by the product, deserve the greatest respect and the most wholehearted praise.

A committee of the association very soon formed a liaison with a similar committee from the American Association of the History of Medicine. A joint editorial board, with members from each organization, lost no time in getting to work. The ground to be covered was mapped out, contributors were selected, and preparation went on apace. In the centenary year, the volume appeared.

Everything about it speaks plainly and insistently of zeal and loving care. Looked at from without, it is a handsome book. Glancing through it, one is impressed by its physical qualities—good paper (something noteworthy in war time), pleasing letter press, good

illustrations. The preliminary impression is favorable and enticing, but these things, good as they are, do not make a book. He who reads will soon find out whether or not the production lives up to its promise. There can, one believes, be but one conclusion in the present instance. The promise is made good.

This is a history of American psychiatric thought and accomplishment. Contemplating the list of those who in one way or another contributed, one cannot but be impressed with what America—using the term in its broad geographical sense—means. Here the father of the idea was a Canadian; those who brought it to fruition are citizens of the United States, but also representatives of many different lands and ethnic backgrounds. Where else on earth could such a thing be done? Where else could such a purpose be conceived and consummated in such satisfying fashion?

Perhaps one might say that this is the history of another One Hundred Years' War—for there was plenty of clashing in the century. History may be the lengthening shadows of men—and such men are likely to be thoughtful, aggressive, and determined in their conceptions. Clash and some bitterness are inevitable. But if we do think of this as war, it was a war vastly different from the usual kind. Of destruction there was none. Constructive effort was the keynote. All worked toward that which to them seemed good. Only the way along which progress should move was differently conceived.

Appropriately, the book opens with a brief account of its own life and purpose. The editor-in-chief and his associate outline briefly the steps leading to the production of the volume.

Before sketching the history of the American Psychiatric Association, in and about the activities of which progress has centered, there are sections devoted to background both in America and Europe. Prior to the mid-nineteenth century, the culture of the Western World was largely derived from the older cultures of Europe. This will be freely accepted by all. A minor wonder, therefore, occurs to one in connection with the planning of the book—it is why in such circumstances the section on American background should precede that on the European background. No doubt there were reasons for this, however, and in any case a mere matter of arrangement detracts in no way from the value of the chapters themselves.

In those early years, American psychiatry, if it could be called such, reflected pretty thoroughly the level of interest and thought abroad. There were no special problems of incidence or unusual types, but there was the same resistant initial predominance of the theological point of view, the same reluctant subsidence of belief in the supernatural and mystical, the same story of the superseding

of ecclesiastical by community or state care, and the rather pitiful inadequacy of the latter. There was little evidence of anything that might qualify as research, but this was the state of medicine generally. The only names representing progressive thought were those of Rush and Upham. Clinical pictures were confused largely by a multitude of fantasies as to causation, based largely on a materialistic philosophy.

In Europe the situation was much the same, except that there vague, preliminary stirrings of something worthy of being called research were appearing and slowly progressing. Clinical records of high quality, pathological reports of similar quality were being assembled; concepts were growing up; the process of disease delineation was expanding. The great names of the period sufficiently attest to the activity of the time, but not a great deal of this activity was directed along psychiatric lines. There too, however, evidences of public and professional conscience relative to mental care were appearing.

The association came into being in October, 1844. The thirteen physicians, all superintendents of mental hospitals, who gathered in Philadelphia were men of "high resolve and determined purpose." They were respected men who were not satisfied with merely doing their own daily work well according to their lights. A hunger for betterment and progress in the field of endeavor each had chosen urged them to associate for exchange of ideas and discussion of the problems that each had faced and tried to solve. The brief sketches of their individual lives leave no doubt as to their thoughtfulness and earnestness.

Their labors started a progressive improvement in institutions for the mentally ill and a corresponding betterment in care and treatment. Dr. Samuel W. Hamilton tells of the successive transitions from jails, workhouses, and almshouses through the era of massive, barracklike institutions of rather ominous repute, to the modern type of hospital, with its adequate facilities for housing, care, investigation, and treatment. He has much to say about restraint, nursing, and the educational function of the hospitals. Some very interesting tables, comparing the hospitalization ratios, the ratios of staff to patients, the yearly per capita costs in the various states, and the dates of founding of the hospitals must have entailed exhaustive search of records.

For fifty years the association and the institutions represented in it devoted attention largely to administrative problems. Weir Mitchell was bold enough in 1894 soundly to castigate the organized psychiatrists for their unhealthy isolation from the medical world

and their failure to carry out scientific investigations. Whether because of this chastisement or simply because time and honest effort were quietly at work directing thought along other than administrative channels, an era of investigating, recording, and publishing began almost at once. Interests both broadened and deepened. Concentration on old problems has gone on simultaneously with a reaching out into related medical and social fields. Successive advances have been grounds for much acrimonious debate and "shrill dispute." But much of this, as Dr. Whitehorn says, has been laid aside as "the poise of mutual respect" gained the upper hand.

One could anticipate from this that the story of the development of psychiatric literature would be similar, and this turns out to be true. Dr. Bunker notes that in the first fifty years of the association, but three journals came into existence and but one survived. The second fifty years tells a different story. The one journal mentioned above—the *American Journal of Insanity,* now the *American Journal of Psychiatry*—has maintained a vigorous and dignified life and has well represented the advances in psychiatric thought and practice. Other journals have appeared, and in the bibliography at the end of the chapter on psychiatric literature, fifteen journals are listed as regularly appearing. One, *Diseases of the Nervous System*—a comparatively recent addition—is not noted.

As for books, there has been a growing current of production since the appearance, in 1812, of Rush's *Medical Enquiries and Observations Upon Disorders of the Mind.* Dr. Bunker, in his list of important publications since 1916, lists 74, and a glance over the list ought to convince any one that these were real contributions.

A survey of therapy is not quite so simple as one might momentarily suppose, for the reason that real contributions have originated in so many associated fields. Dr. Malamud presents a well-integrated account of these many contributions and of the rise and decline of the many therapies that have appeared, lived their little hour or two, and gone. One notes with comfort and satisfaction the growth of the rational and the decline of the strictly empirical forms of treatment. One wonders how some of the latter ever attained the vogue and support that they did have. The emergence of biological and social therapies is emphasized. In an ingenious analysis of papers presented in meetings of the association, Dr. Malamud has been able to show graphically the rather remarkable increase in the past fifteen years in the number of those devoted to treatment, and a further analysis indicates the present lively interest in psychotherapy, occupational therapy, and shock therapy.

Mental hygiene inevitably calls to the minds of the present genera-

tion the name of Clifford Beers. Mr. Deutsch shows that the term apparently first came into use in 1823, when it appeared as the title of a book by Dr. William Sweetser. In the following years other volumes appeared at rather long intervals, and as early as 1832 attention was directed by Brigham to what is known to us as child guidance. A real, but unfortunately short-lived organization appeared in 1880. In it and around it there developed a wild campaign of vociferous charge and countercharge with much whole-hearted mud-slinging. Four years seems to have been the life of this association, and then there was relative subsidence of interest. Beers's disclosures shattered quiet complacency thoroughly, and from then on mental hygiene took on new life, and the influence of its principles has spread over the entire world.

Three chapters on military psychiatry tell the story during three wars—the Civil War and World Wars I and II. During the first of these conflicts, the *American Journal of Insanity* contained not one article on psychiatric problems relating to war, and its parent organization exerted itself only to the extent of protesting once the iniquity of turning mentally disturbed soldiers loose without guidance or assistance. There were, however, worth-while observations and reports, and it is a pity that with the end of the war they were all but forgotten.

The lessons of World War I, in which an effort to make use of mental hygiene and psychiatric principles and experience was made with promising results, were not entirely lost when World War II broke out. The subsequent story of experience and results ought to be of great value.

Dom Thomas Moore deals with the relationships between psychology and psychiatry and dwells on the possibilities in psychological material and techniques not yet evaluated in psychiatry.

The growth and development of psychiatry as a specialty is well portrayed by Dr. Bunker. The specialty, originating when the first physician turned his whole efforts to the care of mental patients, has had its position strengthened by the provision of special hospitals, the emergence of psychiatry as a subject for instruction in medical schools, and the growth of mental hygiene and child guidance. Making contributions to medicine far beyond concern with the care of the "insane," psychiatry has not only established its position as a specialty—it bids fair to assume an important place in the practical working of all specialties.

Dr. Zilboorg's essay on the legal aspects of psychiatry is, as one would expect, a complete, thoughtful, and fair survey of a subject on which the divergence of views, once so great, steadily diminishes.

The last chapter, on anthropology and psychiatry, is in a sense a progress report, indicating a good bit of cross-fertilization, as the author puts it, between the two. Rapprochement has been slower than one would have expected, with the preponderance of influence so far being from psychiatry to anthropology.

The index in a volume of this kind must be an important section and here certainly no complaints can be offered. Thirty three-column pages is a commendably high ratio.

There is a certain amount of repetition in the book, but it would be impossible to avoid it in a survey such as is attempted. One feels sure that psychiatrists and many others will welcome this splendid review of backgrounds against which the present may be measured and the future planned.

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New Perspectives on Peace, A Symposium by Ten Authorities. Edited by George B. de Huszar. Chicago: University of Chicago Press, 1944. 261 p.

The Walgreen Foundation has published this as the thirteenth of its "Studies of American Institutions." Its basis is the notion, so intriguing to us all, that the solution of as complicated a problem as peace should be built of many sorts of material. Pretty much the stuff we need is delivered, but assembly is not even started. Four of the authorities—there are ten from widely dispersed disciplines—are at pains to point this out, and it has not been above a few to thumb their noses vigorously at the neighboring piles of building matter. If the reader finds the result a little bewildering, he can console himself with the statements through the volume that a simple and easy peace structure just would not stand up.

Each of the eleven (De Huszar contributes an excellent introduction) papers is interesting and readable. (McKeon as a philosopher has to be read twice and one still has that disturbed feeling that there is more in the paper than one has recognized. Its excellent assay of the relationship of partial approaches to one another and to the total problem repays the somewhat tortured perusal.) None makes any startling contribution; each is, rather, a sound, careful summation of what this discipline can offer to the problem. Some (*e.g.*, Colby as a geographer) are careful to confine themselves to what their disciplines can offer to the problem of peace. Others (*e.g.*, Ogburn as a sociologist) depict the entire problem as it looks from the point of view of their particular disciplines.

The result is not too happy; one has to orient one's self anew in each new chapter. Nor is the matter helped by the lack of a definition of peace. Some papers are solely interested in the end of martial conflict; others more inclusively wonder about the end of all aggression. All but two rest fairly solidly on the assurance that without the will of the common man for peace, nothing will avail. But without exception the authorities seem very skeptical of the presence of that will for peace in any very driving or articulate form.

The student knows each of these authors. They are authorities to whom we all listen. The very clarity and incisiveness of each contribution makes it difficult to adjust one's self to the approach and definitions of the next paper. If a master plan or a common thread of approach seems too naïve, at least it gives something that the reader can bite into or think against. Where one has to make constantly new appraisals, one cannot begin to envisage a final structure. There is, of course, no playing off of one against another, but the reader almost must feel that way as he goes through such a collection. This involves some waste of extremely good material.

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BROTHERS UNDER THE SKIN. By Carey McWilliams. Boston: Little, Brown, and Company, 1943. 325 p.

Many authors in the field of mental hygiene have held that frustration is an outstanding cause of neurotic tendencies and that the neurotic personality shows his unfortunate attitudes toward life by his resistances and withdrawals.

To quote from two well-known workers in this field, Dr. Karl A. Menninger, in *The Human Mind,* says, "Neurotic patients are those whose childhood development was such that the conflicts between their instinctive tendencies and the environment were never resolved in a way wholly satisfactory to the ego and who are, therefore, constantly impelled to indulge in behavior which gives them a needed satisfaction at an exorbitant cost." And Dr. Karen Horney, in more recent books, *The Neurotic Personality of Our Time,* and *Self Analysis,* lays great stress on cultural influences as well as environmental. She holds that "neuroses are generated not only by incidental individual experiences, but also by the specific cultural conditions under which we live; in fact, that cultural conditions lend weight and color to the individual experiences and in the last analysis determine their particular form."

Translating these comments into characterizations of group mores

rather than individual traits—which can be done with enough validity to be illuminating—this impelling book by Carey McWilliams forces one to the conclusion that the United States has been engaged for many years in creating neurotic minorities within a nation fairly extravert and still adolescent with regard to human relationships.

The chapter headings are stimulating. *The Non-Vanishing Indian* is the first. This chapter brings home with something of a shock to the rather complacent and dominant white man our complete failure to perceive the importance of the cultural environment. We have almost lost the value of this alien culture as a possible contribution to a real American civilization, but more than that, we have induced in the Indian a sense of not-belonging, a helplessness in the face of strange customs of stranger masters, that leads to the reverse of sound mental health, both for individuals and for communities. Moreover, our attitude toward this one of the colored minorities in America has hardly been healthy for ourselves. Frank facing of a problem is a prerequisite for mental health; we apparently have been afraid to acknowledge the existence of distinct racial groups in this country, or we have not known how to do this without becoming nationalistic or superior.

Mr. McWilliams closes this chapter with a telling statement from the present Commissioner of Indian Affairs, who differs from all but his immediate predecessor in his recognition of the importance that contact with a dominant culture has for the minority group. All colored minorities face a problem, McWilliams believes, that, to quote Commissioner Collier, "is in essence a problem of the whole world and one which must be solved if we are to achieve an ordered stability in the international and internal relation of states. It is the problem of reconciling the rights of small groups of people to cultural independence with the necessity for larger economic units demanded by modern methods of production and distribution. This is the problem of small states and small cultural groups everywhere." We cannot logically believe that this problem will be solved in the world until we are able to deal with it more constructively in this country.

This is our first failure in time, and possibly in importance. *The Long-Suffering Chinese*, the second chapter in the book, is a most painful one to the reader, but less a matter for mental-hygiene consideration, as the Chinese have a country of their own, the greatness of which we are slowly coming to realize. This realization should assist in our own national growing-up if we face it frankly. But our inability to free ourselves from fear is doubly apparent as we link the question of the presence of aliens in this country with our timidity about questions of labor relations, and continue to insist

upon excluding from citizenship members of this outstanding race. Are we large-minded enough to regard the problem of migration after the war "as a world problem, to be handled by free negotiation and compact between all the nations of the world"? We can prove here our ability as a nation to adjust to new situations.

In the chapter headed *The Forgotten Mexican,* an important phase of the question of neuroses emerges. Dr. Horney has stressed the probable development of aggressive tendencies as a result of frustration. Before dwelling on Mexican aggression, now actual rather than probable, let us look at its relationship to our own mental attitudes. We have talked a great deal about a good-neighbor policy. We are treating members of our nearest neighbor nation with cruel discrimination, as marked in some Southwestern states as discrimination against the Negro is in the Southeast—and in some ways in the Northeast. Divided attitudes, loyalties, beliefs are never healthy. We say one thing and do another—"and there is no health in us." The Mexican sense of family, of village membership, is very strong. Those who are born American citizens are ready to transfer this loyalty to the adopted country of their parents—whose devotion to the United States is impressive. But they are not permitted in many parts of our West to make such transference. In Los Angeles they are showing a very understandable reaction to that sort of bitter frustation, and we are losing a culture that has much of beauty and a devotion that could well be used at this or any time.

In relation to the Japanese—*Our Japanese Hostages* is the chapter heading—the author quotes from Dr. Edward K. Strong, of Stanford University: "Cultural and racial democracy we do not yet have in America, and until we do have it, our democracy is painfully and tragically incomplete. Progress is also slow because we all assume so absolutely that our own views are the only true ones; hence all differences are signs of inferiority. We must learn that practical equality can exist with essential differences and that differences do not imply inferiority."

This quotation applies as well to all that the author tells of our treatment of the Hawaiians, the Filipinos, the Puerto Ricans, and other islanders. The story is very complete and dramatic and heartbreaking. It is unusual to find a book so well documented, so scientific in tone, and at the same time so absorbing. It is hard to stop reading until the entire story is told. And in spite of the clear-sighted way in which the author sees our failures, the note of pessimism is lacking. There is much that can be done, and Mr. McWilliams does not shirk this more difficult part of his work.

This constructive attitude is shown particularly in his chapter,

The Negro Problem: A Case History. At the beginning of this discussion the author points out a marked weakness in our handling of the problem: "While undoubtedly there is a great deal more to be learned about the Negro, relatively he has been overstudied. In point of fact there is actually something rather unwholesome about the accumulation of such a bulky literature on a particular problem when that writing is so barren, as it happens to be in the case of the Negro, of definite suggestions for social action."

McWilliams confines himself, therefore, to giving the history of the Negro minority in the United States after it became a problem, which, he says, was not until after the Civil War. Before that time slavery, not the Negro, was the problem that engaged our attention. "With the passing of the old order in the South, the Negro problem had increased in magnitude and importance." And it has continued so to increase.

Southern colleges, supported largely by funds from the North, began to send out their graduates, many of whom migrated to the North and there found more subtle discriminations, sometimes harder to bear than the open condescension or frank hostility of the South. As an educated colored woman said to this reviewer, "We don't know what we can do nor where we can go." Such conditions are not conductive to mental health on either side. We Northerners are far from being integrated in our attitude toward this question. The educated Negroes are rapidly increasing in number, are ambitious for their children, as is any educated person, white or colored, and are becoming openly rebellious about these deprivations of civic rights.

McWilliams' account of the effect on the Negro of his experiences in the first World War is illuminating and disturbing. "To fight a war a democracy must have a measure of internal unity; war naturally serves, therefore, to emphasize basic faults in the social structure. Aroused by the stirring slogans of 1918, Negroes were soon made to realize that they were second-class citizens. Appealed to in the name of democracy, they were constantly discriminated against in the armed forces." During the depression, "'Last hired, first fired,' became the order of the day, as Negro dependency mounted in all areas of the nation. It became quite obvious that Negroes were suffering proportionately greater hardships than whites."

Social-service studies and efforts and scientific attack on the question of racial inferiorities have changed the background of our thinking, but we continue to be divided personalities—intellectually recognizing the dicta of various authorities, emotionally clinging to our sense of race superiority. Of course, the effect on the edu-

cated Negro is far more serious. And because of this effect, we are losing valuable contributions to American culture from potential artists of that race. A few are great enough to emerge, but we shall never know how many mute, inglorious Miltons are beaten down by our social buffetings, or are using their abilities in aggressive behavior of one sort or another.

All these considerations are of vast importance during the present war. McWilliams quotes Robert Sutherland: "Since internal unity and coöperation are as much a part of national defense as are battleships and fortifications, the importance of allowing no large minority to feel arbitrarily excluded is obvious."

The last chapter, *Outline for Action,* distinguishes this book from so many others of this general sort. Here the author takes his stand "toward an affirmative policy." A fair racial policy would enlarge the rights of all, not merely those of minority groups. The dropping of discriminatory actions would make it possible to choose one's friends or co-laborers where one wished to. We must become sufficiently adult to stop judging people as groups and to be able to select on the basis of individual ability or sympathy. And after putting before his readers several concrete and stimulating proposals calculated to appeal to the intelligence of each of us, the author closes with this definite warning: "These problems [of racial minorities] are not 'solved' merely by the declaration that 'imperialism' must be banished from the post-war world. The problems of adjustment, of acculturation, of cultural conflict, remain. By taking the initiative here, we might be in a position to assert real world leadership in relation to these same problems after the war. On the other hand, by continuing an ostrichlike do-nothing policy at home, we are certainly inviting another Versailles."

The book is filled with illuminating quotations from books and articles by qualified students of racial problems in all their many forms. It would be made even more valuable if there were an index and more specific references to the authors quoted. But the combination of careful study and passionate concern for this outstanding weakness in the American set-up has resulted in an absorbing and convincing volume.

ELEANOR HOPE JOHNSON.

Hartford, Connecticut.

PSYCHOANALYSIS TO-DAY. Edited by Sandor Lorand, M.D. New York: International University Press, 1944. 404 p.

Although produced by a different publisher, this volume can well be viewed as a reëdited and enlarged second edition of the book by the

same editor with the same title published by Covici Friede in 1933. In this new volume eight new contributors have been added and three former contributors are missing. Most of the essays on the neuroses and psychoses are unchanged. A few have been reëdited. The former articles on paranoia and schizophrenia have been fused into one on schizophrenia. The essay on psychoanalysis and anthropology, by Geza Roheim, has been completely rewritten.

There are three new essays relating to psychosomatic medicine, written, respectively, by Jelliffe, Dunbar, and English. The following are either new titles or old titles developed by another author: *Child Analysis,* by Marianne Kris; *Juvenile Delinquency,* by I. T. Broadwin; *Psychoanalytic Social Work,* by Marion E. Kenworthy; *Mental Hygiene,* by Jule Eisenbud; *War Neurosis,* by Ernst Simmel; *The Technique of Psychoanalytic Therapy,* by Sandor Lorand; *Psychoanalysis and Sociology,* by Heinz Hartmann; and *Approaches to Art,* by Ernst Kris.

In the preface the editor states that his "aim has been to depict the progress in psychoanalytic research and to give to psychiatrists, medical men, social workers, educators, and others to whom the problems of contemporary life are important, a comprehensive survey of the contributions of psychoanalysis to the healing sciences and general culture."

The reviewer knows of no other book that meets the need of the serious and intelligent general inquirer so well. The bibliographies appended to the individual essays indicate the path for further study.

One is impressed with the number of essays that remain unchanged from their 1933 form. It is the reviewer's opinion that this is largely because most of the original papers were excellent presentations of fundamental material which still stands on its own merit after eleven years of rapid development in the psychoanalytic field. This volume is heartily recommended.

E. Van Norman Emery.

Washington University, St. Louis, Missouri.

The Psychiatric Novels of Oliver Wendell Holmes. Abridgment, Introduction, and Annotations by Clarence P. Oberndorf, M.D. New York: Columbia University Press, 1943. 268 p.

The method of abridgement that Dr. Oberndorf has used in presenting Holmes's three novels—*Elsie Venner, The Guardian Angel,* and *A Mortal Antipathy*—was a wise choice. With their original wordiness reduced greatly—from more than a thousand pages to less than two hundred—it is possible to read them without becoming too much bored by the stilted, tedious style. The introduction and annotations, which are frequent and fairly long in many instances,

have done still more to transform the dull, old-fashioned stories into tales of absorbing interest. This is indeed a tribute to Dr. Oberndorf's literary gifts and psychiatric acumen, for his footnote contributions are the real source of one's eagerness to go on reading the book and of one's reluctance to put it down until it has been read from cover to cover. In the opinion of the present reviewer, it is certainly fortunate that the footnotes have been included, although this was not the first intention, according to the foreword.

Illuminated by the introduction and notations, *Elsie Venner* is no longer to be viewed as an outmoded tale of prenatal influence upon a child. Instead, it becomes akin to a modern case history of a child with an introverted, isolated personality, lacking in normal affective responses—in short, showing characteristic symptoms of a beginning psychosis. Thus, this novel takes its place along with other psychiatric novels—such as Schnitzler's *Flight into Darkness* and Julian Green's *The Closed Garden*, to mention but two others that chance to come to mind—as a fictional, yet realistic description of the progressive stages of a mental illness.

Similarly, under Dr. Oberndorf's guidance, *The Guardian Angel* appears as an account of adolescent conflicts, amnesia, and multiple personality, while *A Mortal Antipathy* deals with a phobia, tracing the onset of the neurotic symptom to an infantile traumatic experience.

Nor are these general psychiatric aspects all that are to be discovered in the stories. In addition, Dr. Oberndorf has found passages that offer appropriate occasions for discussion of symbolisms (for example, snake and water symbolisms); passages very well illustrating the operation of various mental mechanisms (such as displacement, appersonation, and so on); and material that can be utilized toward an understanding of the relationship between physician and patient, especially with reference to the phenomena of transference and even of counter-transference.

If all this is not indicative of sufficient richness for one small volume, there are also side lights on the history of medicine in this country, as noted by Dr. Oberndorf, and in a sense a preview of what was yet to come in the future, after Holmes's time, since in his writings are foreshadowings of certain concepts more fully developed later in the psychoanalytic theories of Sigmund Freud.

In brief, this book contains not only considerable general psychiatric theory as to the etiology of mental illness and neurosis, but also many finer points of psychiatric and psychoanalytic theory and techniques. It is to be highly recommended for use in courses in psychiatry or abnormal psychology as a supplement to formal textbooks. It should be invaluable reading for the student of medi-

cine and psychiatry, or for students in the field of psychology and social work who need psychiatric orientation as a part of their professional education.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

DELINQUENCY AND THE COMMUNITY IN WARTIME. Edited by Marjorie Bell. (Yearbook of the National Probation Association, 1943.) New York: National Probation Association, 1943. 301 p.

When Mr. Reinemann, of the Philadelphia Children's Court, reviewed the 1942 Yearbook of the National Probation Association in the April, 1944, issue of MENTAL HYGIENE, he said:

> "Book reviews must frequently be considered inadequate and unfair to reader, interviewer, and author alike, as they attempt to report and appraise the contents of several hundred pages in little more than as many sentences. This is even truer in the case of a book that is a compilation of contributions from more than a score of authors."

This reviewer finds himself in precisely the same position when he attempts to deal with the 1943 Yearbook of the association.

Despite our hopes and wishful thinking, crime has not been suspended for the duration. If anything, the war has created new types of crime and of persons who commit them. It has brought into being new types of delinquent behavior, and is responsible for an appalling increase in crimes committed by minors. For all that the primary energies of the majority of us are or ought to be concerned with the advancement of the war effort, we are faced with the necessity of making some realistic contributions toward the solution of war-time delinquency. Some of these contributions appear in the considered opinions of the men and women whose papers make up the mosaic of the National Probation Association's 1943 report.

We cannot afford to be pessimistically complacent enough to say that every one knows that the social and economic dislocations implicit in the times breed their crops of crime, and simply sit down to punish those individuals who are unfortunate enough to be caught. If we are to believe what we are told about fighting this war to make this a better world for all men everywhere, then we might profitably devote ourselves to considering the personal and social maladjustments that express themselves in crime. More than that, we are required to give thought and to counsel action looking toward the elimination of some of the causes and conditions of crime. That this is truer in war time than in peace time is something that needs little amplification.

It is well, then, that Mrs. Bell placed Professor Donald Taft's paper, *American Culture and the Treatment of the Offender*, at the head of

the procession. Mr. Taft demands that we attempt to define crime much more exactly, and points out its seeds in the cultural pattern: competition, the need for getting ahead in the world, racial discriminations, and the felt need of all of us for status. He mentions the cynical feeling, not altogether untrue, that every one has a racket, and that not the least of the racketeers are those whose business it is to watch over the other racketeers who have been caught in the toils. He suggests in all seriousness that it might be a good idea to teach criminology to probationers and prison inmates.

> "As a result of such discussions, probationers and inmates may discover that not every one has a racket. Maybe their own overpowering sense of failure may be reduced by seeing themselves not as a class apart, but as elements in the general problem of failure to socialize. . . . When a genuinely coöperative frame of mind is achieved, the battle is more than half won."

War-time changes in probation and parole are discussed, as would be expected, by men and women actually working in the field. Chief Probation Officer Conrad Printzlien, of the Brooklyn Federal Court, considers ways and means of meeting war problems in probation and parole. In the most thickly populated federal probation district, approximately 1,000 probationers and parolees are supervised each year.

Mr. Printzlein deals with the efforts of the Probation Bureau to relate their charges to the war effort—through the armed forces or through working in war-related industries. He tells of his efforts to convince army and navy recruiting and induction officers that not every man convicted of crime is hopelessly unfit to serve his country. Nor, on the other hand, are the armed forces to be used as dumping grounds for criminals. Despite the fact, as Mr. Printzlein points out, that there is no escape from the necessity of handling problems *en masse,* it is always possible to devise some measure of flexibility in all laws and regulations, so that we can make some pretense of individual study and treatment of the problem of war-time activity of every probationer and released inmate. He also tells of the new work coming into the probation department by reason of the new crop of crimes growing out of violations of the Selective Service and Training Act of 1940. Like Gilbert and Sullivan's policeman's, the probation officer's lot may not be a happy one. But apparently it has its moments.

Articles by Eliot Ness, Whitcomb H. Allen, and Raymond F. Clapp, of the Federal Security Agency, make up the section devoted to the Federal War-time Protective Program. These concern themselves with a venereal-disease-control program, protection against infection of members of the armed forces, and consideration of the camp fol-

lowers and the social dislocations connected with the establishment of new war-time communities which are unable to supply proper housing, recreation, and welfare acivities.

Whitcomb H. Allen's paper, *Young Camp Followers,* merits careful reading and study. It has been pointed out that this country is as yet unready to undertake a realistic program to eliminate prostitution and venereal disease. One case-hardened police commissioner was willing to be convinced from actual records of the time losses to the armed forces through the disabling effects of syphilis and gonorrhea. When he was shown, he closed his red-light district in less than twenty-four hours. Repression, Mr. Allen points out, is not enough; something must be done for the girl or woman who becomes involved in prostitutional activity. Prostitution is only the surface indication of personality dislocation, and treatment for the woman is much more complicated than removing her from activity and teaching her a trade. Despite the fact that the Federal Security Agency feels that we are not yet ready for a realistic attack on the social-hygiene front, the job ahead of us is educational and preventive rather than repressive.

Foremost in the popular thought of crime are the offenses committed by what are legally termed "infants." Juvenile delinquency is being discussed in ways both wise and otherwise by preachers, radio commentators, the movies, the politicians, and the criminologists, both professional and amateur. Basil L. Q. Henriques, Chairman of the East London Juvenile Court, leads the discussion on "War and Juvenile Delinquency" with a paper entitled *The War-time Delinquent in England.* It describes the workings of the children's courts in England and Wales—a process both like and unlike that familiar to us in the States. For all the informality of court procedure, the court is just as careful to determine the guilt of the offender as if he were tried in an adult court, and offenders over fourteen may demand a jury trial.

As here, first offenders are usually placed on probation. The court may order a whipping when the boy is between eight and fourteen, although Mr. Henriques seriously questions the efficacy of this form of treatment. Boys for whom probation is unsuitable may be sent to an approved school, and for these schools it is claimed that they are able to work out a favorable result in as high as 90 per cent of the cases sent to them.

Despite blitz conditions, the children's courts did business as usual, and Mr. Henriques expressed some delight that his records were destroyed somewhere along the way.

"I am glad that happened," he says, "for the proper attitude between the probation officer and his probationer should be that of friendship, and no one keeps case papers for his friends. One

requires a record of names and addresses, but relies on memory to sum up personalities. There is a tremendous danger of looking upon probationers as cases and not as friends, and the real work of probation lies in the influence of the personality of the officer upon the child."

He speaks of the great increase in juvenile delinquency since the outbreak of hostilities, and of the efforts made in Britain to serve potentially delinquent youth. The creation of recreational activities for boys and girls and the pre-service training corps are specially noticed. He feels that the community must satisfy the child's need for adventure and give him a genuine sense of participation in the war activity. In other words, the child must feel that he belongs.

In the section on delinquency-prevention movements, Harold H. Krowech, Chairman of the Juvenile Crime Prevention Committee of California, suggests what the bar might do in a crime-prevention program; Ira L. Brought, of the U. S. Secret Service, tells of an educational program with respect to counterfeiting; and Professor Ernest W. Burgess discusses a program for preventing delinquency as proposed by the Chicago Recreation Commission.

In the section on the community care of delinquent children, thoughtful articles have been submitted by recognized workers in the field. Inspector Roy Casey, of the Federal Bureau of Prisons, draws a discouraging picture of children in jail. Literally tens of thousands of children throughout the country are held pending trial in jails of which the less said the better. States priding themselves on being progressive are without proper provision for the detention of young offenders, and hold them, pending the outcome of court proceedings, in jails condemned as unfit for habitation even by adult criminals. The possibilities of throwing youngsters into close association in jail with drug addicts, tramps, sex offenders, and men skilled in crime needs little amplification here. *Res ipsa loquitur.*

The section on psychiatric studies, juvenile and adult, should be given extended notice. All three of the papers in it are significant and important. Space, however, does not permit extended notice of them, and abstracting is such an unwise method that it will not be attempted here.

The report concludes with the usual legal digest of happenings of legislative and administrative significance for professional workers in the probation field.

Thus, in reviewing a work of composite authorship, we end where we started: no one will be satisfied with this review, least of all the reviewer.

ALFRED A. GROSS.

Committee for the Study of Sex Variants, New York City.

CRIMINOLOGY; AN ATTEMPT AT A SYNTHETIC INTERPRETATION WITH A CULTURAL EMPHASIS. By Donald R. Taft. New York: The Macmillan Company, 1942. 708 p.

As a study in social relations of a particular type, criminology is only an offshoot of sociology and as such pursues the method that has been a part of the general sociological approach. For years it has been influenced by other sciences and has borrowed liberally from the related sciences of biology, anthropology, psychology, and so on. So that in a sense sociology has been generally a compilation of material gathered from other sciences and put under one heading, with virtually very little material of its own. Like the witches' brew in *MacBeth*, it has a little of everything; but unlike that brew, it is not very powerful.

The criminal has been viewed in terms of biology as a mutant or an exception that runs counter to the general gamut of accepted behavior. Anthropologically, criminology has tried to digest Lombroso's ill-fated concept of criminality as an expression of degeneracy, which, although definitely refuted by modern understanding, still finds its place in the various discussions on criminality. On the psychological side, it has tried to measure the intelligence level of various criminals, hoping to find therein some difference that will delimit the criminal from the general population.

All these attempts appear to have failed. The more dynamically oriented student no longer looks upon the criminal as a mutant, a degenerate, or an intellectual inferior. The one single approach yet left for the criminologist to pursue—namely, the individual dynamic approach—has hardly reached the criminologist, although some feeble attempts in that direction are being made. It has remained for psychiatrists, more particularly those concerned with mental hygiene and the extramural behavior of children and adolescents, to hit upon the basic core of criminality in studying the various types of behavior deviations.

Of this, unfortunately, we get very little in the book under review. What Dr. Taft gives us is a good all-round, albeit stereotyped study of criminalistics. A great deal of space is devoted to such social factors as the relation of population to crime, the effect of races, economic conditions, and so on. Very little has got in of the more dynamic understanding of criminology as envisioned by modern psychiatry. This, from our point of view, is the book's basic limitation. What we need is less discussion of conventional material and more, much more, of the dynamic factors that move one individual of a family of ten to become a criminal and another member of the same family, brought up under like environmental circumstances, to become a successful social leader.

But perhaps we are expecting too much of criminologists. After all, they have very little chance to study individual criminals as psychiatrists have. Their point of view inclines them toward group study rather than toward individual studies. Hence it is hardly fair to expect of them a book that will be dynamically oriented. Within the limits of its framework, Dr. Taft has produced an all-round study of the various social factors involved in criminality, and as such it may be recommended for classes in sociology and criminology. The chapter on the Negro in crime is very sympathetically written. Altogether disproportionate attention is given to the problem of parole and judicial measures. The last chapter, *The Criminal Nation,* discusses very suggestively the wider implications of criminology, comparing especially crime and war. The reference list is ample, and the name index and subject index are entirely adequate.

BEN KARPMAN.

St. Elizabeths Hospital, Washington, D. C.

THE HOSPITAL IN MODERN SOCIETY. Edited by Arthur C. Bachmeyer, M.D. and Gerhard Hartman. New York: The Commonwealth Fund, 1943. 768 p.

This work is a collection of material taken from periodical literature on various phases of hospital administration and allied fields. The latter purports to embrace certain aspects of medicine, public health, management, and organization, law, sociology, and psychology. This rather ambitious scope, however, is somewhat nullified by the statement in the preface that it "does not pretend to be an exhaustive compilation of all the significant material in these fields."

These collected papers, originally published prior to 1940, are assembled in one volume as a convenience to hospital administrators and to students in the field of hospital administration. They represent the combing and selection from the literature of certain articles for reproduction or as references for supplemental reading. For the most part editing "was confined to making spelling and punctuation consistent. In a few instances, a supplementary note was added to an article whose subject matter is out of date or whose author has modified his views."

In compilations of this character, assembled for the convenience of students and pertinent to others interested in the subject matter, it is usual to look to the editor for comments and guidance regarding controversial material. One reads, however, in the preface that the editors and publishers accept no responsibility for any of the statements appearing under the names of the authors of the various articles reproduced. Obviously, editors are expected ordinarily to assist

and guide the reader by editoral comment that evaluates the soundness of the original author's point of view The absence of these editorial comments and guides detracts somewhat from the value of the compilation.

On the whole, however, this collection of papers makes available in accessible form the more pertinent literature dealing with the subject matter.

The volume embraces five parts. The first deals with the history and scope of hospital service. The second deals with the relationship and functions of trustees, organization, and management. The third takes up the organization of the medical staff; nurse education and nursing service; and surgical, obstetrical, x-ray, out-patient, and other special services. There are articles on social service, laboratories, and pharmacy. Part IV deals with such subjects as admitting and discharging patients; financial control; legal responsibilities; construction; plant management; purchasing; food, housekeeping, and laundry services; and personal matters and public relations. Part V concerns itself with group hospital and health insurance and the rôle of the general hospital in public health.

The book is without a general index, but has a complete table of contents and authors' index.

One may consider the volume rather in the light of a clerical compilation and the republishing of selections from previous contributions made to the current literature in the hospital field. In this respect it has some value as a personal-library reference book.

W. L. Treadway.

U. S. Public Health Service, Los Angeles, California.

NOTES AND COMMENTS

Compiled by

MARY VANUXEM, PH.D.

New York State Committee on Mental Hygiene of the State Charities Aid Association

THE LASKER AWARD FOR 1945

The Lasker Award for 1945 will be given for an outstanding contribution to the rehabilitation of the mentally handicapped. The National Committee for Mental Hygiene is now receiving nominations, with supporting data, to be presented to an anonymous jury selected for its competence to judge accomplishment in the field chosen.

The award of $1,000, established in 1944, is made annually in November by the Mary and Albert Lasker Foundation for meritorious service and significant contributions to the promotion of mental health and of public understanding of mental hygiene.

Colonel William C. Menninger, M.C., Chief Consultant in Neuropsychiatry, Office of the Surgeon General, U. S. Army, was the first recipient of the award, for his outstanding contribution to the mental health of the men and women of our armed forces.

"MODERN HOSPITAL" ANNOUNCES PRIZE COMPETITION

A competition open to essays on the subject, "A Plan for Improving Hospital Treatment of Psychiatric Patients," has been announced by *The Modern Hospital,* of Chicago. Three prizes are offered—a first prize of $500, a second prize of $350, and a third prize of $150. Three outstanding authorities on the hospital treatment of psychiatric patients, drawn from the United States Public Health Service, The American Psychiatric Association, and The National Committee for Mental Hygiene, will judge the essays, which must be in by October 1.

The leaflet announcing the conditions of the competition states as follows the purpose for which it is being held:

> "The sorriest spectacle in hospital service to-day is the treatment accorded the psychiatric patient. Herded in a large isolated state hospital or in an unstandardized proprietary or voluntary institution, the patient often gets little more than custodial care. His medical care may or may not be scientific and efficient; his doctors, although often devoted, are usually underpaid and overworked. His nursing care is

likely to be skimpy. His attendants may be poorly trained or indifferent and sometimes even brutal. Often nobody takes time to outline and carry on a program of intensive and constructive therapy which fully utilizes present knowledge. Some state and voluntary hospitals, of course, are exceptions; a few are very superior institutions indeed. Generally speaking, neither the profession nor the public has effectively demanded that standards for care of psychiatric patients be maintained at a high level, that adequate funds be provided to operate good psychiatric hospitals or units, and that staffs be top grade and kept at the highest pitch of enthusiasm and ability. The public has a large responsibility, but it needs aggressive and courageous professional leadership.

"Each state and community in the United States and each hospital providing care for these patients should have a plan for improving its hospital treatment so that as many as possible can be restored to their families and their home communities. For a community or state such a program involves: (1) the training of an adequate number of competent psychiatrists, psychologists, psychiatric nurses, psychiatric social workers, occupational, recreational, and other therapists, attendants, and associated personnel; (2) the encouragement of research that will discover new technics for treating psychiatric patients and will refine and improve existing technics; and (3) the creation of strongly organized public and professional opinion that will demand high standards of treatment and will insist that personnel, physical facilities, and funds be sufficient to achieve such standards. To make a contribution to such a program is the purpose of this competition."

For further information with regard to the terms of the contest, write to the Modern Hospital Publishing Company, 919 North Michigan Avenue, Chicago 11, Illinois.

The Prisoner of War Comes Home

(Reprinted from the *Bulletin of General Information on Service to Veterans,* March 1, 1945, by permission of the War Department and the American Red Cross.)

A conference of military psychiatrists held in England during the fall of 1944 considered the topic, "The Prisoner of War Comes Home." In general, it was found that men who had been imprisoned less than 18 to 21 months showed very good morale and had retained a fairly normal point of view. It was only when men had been imprisoned for longer than this that they began to show significant psychological problems and had difficulty in adjusting themselves to their families and friends. A summary of some of the psychological problems mentioned by three of the speakers follows:

Among the noticeable characteristics of men whose *imprisonment has been long* are restlessness, apathy, and intolerance of authority, rules, or restriction. A report of a conference of ex-prisoner-of-war

warrant officers and sergeants showed that the *following conclusions* had been reached:

1. First of all, prisoners of war want to be allowed to forget they were prisoners. They prefer not to be classified as such.
2. Those from technical corps wish to get back to their own units to review their knowledge of their own equipment.
3. The great majority of ex-prisoners of war have no special conditioning as the result of prisoner-of-war life. On the contrary, they are alert and enthusiastic.
4. They resent "the nonsense" talked about the treatment in prisoner-of-war camps and the great fuss made over their return.
5. They saw little difficulty in everybody getting back to a "normal outlook toward discipline" in a very short time.

An ex-prisoner of war stressed the *lack of change in the outside world;* those who return from prison camps find it "the same old world instead of a changed new world." He went on to say that "the repatriate sees plainly the old faults that are still there and feels that those at home might have done a little better in their attempt to bring about the brave new world for which he was fighting and for which he feels he has given up so much."

The first meeting with his family is an ordeal which is dreaded by the prisoner facing repatriation. *Becoming a member of a family group also requires readjustment.* In a prisoner-of-war camp there are no social obligations. A man may go without eating for a day or longer, if he wishes. He may sit without speaking for hours at a time. At home he must give an explanation for everything he does. After his return, if understanding is lacking in his home, he may come to feel an actual nostalgia for the prison camp's routine and its "comfortable protection from the responsibilities and difficulties of ordinary everyday home life. . . . I think if relatives could be made to understand how difficult it is to reaccustom one's self to family responsibilities after so long a period of looking solely after one's self and one's own interests, they would be a lot more tolerant; and if they realized that when a man appears moody or forgetful of them, or lazy, or even downright selfish, he may be going through agonies of mental rebirth. My own feeling is that relatives who have the common sense to leave a man alone when he feels depressed and moody, and who do not try to 'drag him out of it' do most to put a man speedily on his feet again."

The same speaker emphasized the *mutinous and rebellious feeling toward all authority* which returned prisoners of war often have—attitudes which are bolstered and even engendered by the complete indifference toward repatriates of many of those in authority. He recommended the creation of advisory boards, made up of repatriates

"who now know the ropes," which would be prepared to give advice and help in the many problems of readjustment of returned prisoners of war to life outside the prison camps. The services of such boards, in addition to psychiatric assistance, would, he felt, facilitate the readjustment of these men to a great degree, pointing out that if the "muddles, mistakes, unfortunate misunderstandings and disappointments" with which repatriates meet in their contact with officials and the community in general could be eliminated, very few ex-prisoners of war would require or seek psychiatric help.

Another speaker made the following statement: "It may also be as well to get quite clear that these *repatriated prisoners of war are not psychiatric cases.* This point must be strongly emphasized. It is true that there are psychiatric cases amongst them, just as there are among the general army population." According to his observation, the attitude of the general public toward repatriated prisoners of war goes through three phases—first, sympathy, then pity, and then irritation. He stated that he believes that these men do not need *soft* handling, but require *different* handling. He *listed a number of attitudes and forms of behavior of repatriates which he believes to be characteristic of them.*

1. They are bitter, with a depth and seriousness that should be of concern to all of us.
2. They display a cramped and restricted initiative.
3. They have great skill in the organization of passive resistance against cold, impersonal, or hostile authority, or any authority which can be identified as "Nazi."
4. Their bitterness is covered by a screen of superficial cheerfulness, or, as an alternative, fatigue.
5. They feel a great sense of guilt over having been captured. So deep-seated is this feeling that the speaker recommended leaving this subject severely alone in discussions with these men.
6. Those who have not been actually disabled feel their physical or mental health has somehow been damaged.
7. Their self-respect is easily damaged.
8. They are disillusioned because of the contrast between real life at home and their romanticized versions of it when imprisoned.
9. They evidence a marked social anxiety—are unsure of what is or is not acceptable in their daily contacts.
10. They wish to go home and remain there, mingling with the civilian community and not being identified as repatriates.
11. They need feminine society and "feminine understanding affection." This characteristic, he stated, has no connection with physiological needs.

Friends, relatives, and all called upon to contact repatriates should be able to help by the one essential for their "recovery"—objective, sincere, and patient understanding.

Factors that affect the nature and extent of the emotional problems of repatriated prisoners of war are the *duration* and circumstances of captivity and whether they have been returned because they have escaped from or evaded the detaining authorities or have been repatriated for other reasons.

In dealing with ex-prisoners of war, the following *psychological* points ***must be kept constantly in mind:***

1. They are connoisseurs in sincerity—are "allergic to insincerity."
2. Great bitterness and suspicion is usually concealed.
3. They are skilled in passive rebellion.
4. Their need to get home is compulsive.
5. Discussion and detailed explanation of future plans with groups of thirty to fifty men are necessary.
6. They value greatly the right of personal question and answer as against written orders.
7. Full statements of the difficulties to be faced by each of them, with no promises or evasions, are very important to them.
8. They feel much guilt over their capture and their self-respect is brittle.
9. Their initiative in certain directions is cramped.
10. Prisoners of war have been exposed to democracy through the coöperative arrangements which exist in prisoner-of-war camps in reference to food and some other matters of general welfare.
11. They carry "a vintage mark, usually in the shape of suspicion of authority," as the result of their experiences in such battles as Dunkirk, Crete, and France in 1940.
12. News and discussion of home affairs mean a great deal to them.
13. Their attitude toward the Germans changes in inverse ratio to their distance from the front. Their hatred of the Nazis is at a minimum in the combat area, increasing rapidly as the home base is approached.
14. They do not like to be called "prisoners of war" nor do they wish to be called "prisoners."
15. They react with bitterness and difficulty to sympathy and pity. The only way to earn their respect is by objective understanding and patience.

This same speaker said that successful "handling" of repatriated prisoners of war involves the use *of positive aspects of their past experiences*—as, for instance, the patterns of coöperative activity developed in relation to their supplies of food and other "welfare" aspects of their camp life. He stated as his belief that "handling these men represents early skirmishes in our attempts to win the peace as well as the war."

A Letter to Hospital Commanders

(Reprinted by permission from the *Bulletin of the U. S. Army Medical Department,* February, 1945.)

As commanding officer of an army hospital, you are more than a doctor. Thousands of soldiers come to your hospitals for medical treatment and care, and it is your job to see that they get the very best. But if you treat only their bodies and forget their minds and spirits, you will have accomplished less than your full duty.

Many of these young men who will come to your hospital sick, injured, or wounded have had little opportunity to participate as civilians in adult life. Some have actually achieved adulthood in the army. Of those patients of yours returning to duty, some will go back as combat-experienced soldiers. They know what lies immediately ahead for them, and there will be many unanswered questions on their minds. Skillful, understanding, and realistic guidance will be necessary, not guidance based on talk, but more on that unspoken understanding which exists between those who have shared common experiences. A proper word at the right time will do them more good than an elaborate system of guidance.

Some patients who have missed the struggle of growth from adolescence into adult status, which they normally would have experienced in civilian life, will be disqualified for further military service because of illness, injuries, or wounds. On their return they will enter an adult civilian world to which they will be strangers. The boy who went to war will return a man, a traveler who has seen the world, one who has made new friends and now has a new, broader, and, in some says, unique outlook on life. Home and the home-town folks may not measure up to his new stature. Changes in both will have to be reconciled. The home town will seem small, and the old road to the schoolhouse amazingly short and narrow.

While recuperating from wounds and illness, these men will have much time to think. Here is your opportunity to help them to organize their thinking, to orient themselves with respect to things for which they fought and for which they may fight again, to contemplate their country and its problems and their part as experienced soldiers or as mature citizens in adult civilian life.

As a leader of men, you will seize this opportunity. No one is in a more strategic position than the nurse, the doctor, and the corpsman to know and appreciate the specific needs of patients. It is important to encourage them to consider the life to which they are returning, to take stock of themselves, and to develop self-reliance. In some cases, young men whose life plans have been interrupted by war may be encouraged to gather up the threads again and go

on to weave their own pattern of living. Material for weaving life patterns is available in every hospital if imagination, enterprise, and leadership are present.

But you say you have insufficient personnel. Your staff is as highly educated as that of most colleges. If that staff will see clearly the needs and possibilities and will concentrate effort on cases likely to profit from reconditioning, there is no limit to what can be done. I do not mean that your doctors and nurses will become teachers. Educational reconditioning officers and assistants are provided for that primary purpose, but they need the coöperation of your doctors and nurses who should understand all that is offered to the patient. Treatment of the whole patient, watching closely his progress, encouraging him to participate, taking pride in his mental as well as physical progress, is an essential of good medical care.

Reconditioning is not a specialized function to be performed between certain hours. It is the duty of all the staff all the time, and all must work together to accomplish it. No greater challenge has been offered at any time to any group of men and women, no greater opportunity to serve patients well and lastingly. If you as commanding officer meet this challenge, if you can inspire every doctor and every nurse to consider the minds and spirits of their patients, you will make of them not only menders of bodies, but builders of men.

(signed) N. T. KIRK
Major General, U. S. Army
The Surgeon General

WESTERN STATE PSYCHIATRIC INSTITUTE AND CLINIC OFFERS RESIDENCIES IN PSYCHIATRY

The Honorable S. M. R. O'Hara, Secretary of Welfare for the Commonwealth of Pennsylvania, has announced that the name of the Western State Psychiatric Hospital, Pittsburgh, Pennsylvania, has been changed by action of the legislature to the Western State Psychiatric Institute and Clinic. This change, long under consideration, was brought about to emphasize the important functions of training, teaching, and research, and the operation of the mental-health clinic. In coöperation with the University of Pittsburgh, instruction is given to students in medicine, nursing, psychology, social service, and dentistry.

Six junior and six senior residencies in psychiatry are available. Junior positions offer opportunities in clinical work and teaching.

Senior positions require previous experience in psychiatry, this work being largely confined to the care and treatment of out-patients.

The program for residents has been approved by the Council on American Education and Hospitals of the American Medical Association and by the American Board of Psychiatry and Neurology. Both men and women not subject to military service may be appointed, Pennsylvania residents being given first preference. Later, it may be possible to accept applicants liable for military service if deferment can be obtained. The stipend is $79 per month and maintenance, subject to withholding tax and retirement. Residents must conform to Pennsylvania laws relative to licensure. Application should be made to Grosvenor B. Pearson, M.D., director of the institute. A prospectus of the training program will be sent to applicants on request.

Postgraduate Course in Psychiatric Nursing Established by McGill University

McGill University, of Montreal, Canada, through its School for Graduate Nurses, has established a one-year postgraduate course leading to a certificate in psychiatric nursing.

The course is to begin next September. It will be open to graduate nurses eligible to matriculation in the university who have had sufficient experience in psychiatric nursing to indicate an interest in and an adaptability to such work. The course is designed primarily to provide advanced training for those nurses who are planning to undertake supervisory, administrative, and teaching responsibilities.

The academic program will be provided in the university, and the clinical program through the Allan Memorial Institute of Psychiatry and other approved hospitals.

Reorganization of Michigan State Hospital Facilities

In his message to the 1945 Michigan Legislature, Governor Harry F. Kelly requested an administrative reorganization of the hospital commission. While the legislature did not concur with the governor and the report of a legislative study committee recommending that the administration of the Mental Health Program be under one directing head with an advisory commission, the bill that was passed provides for improvements over the present system.

The bill abolishes the hospital commission and creates a department of mental health, within which a five-member commission is to be appointed by the governor. The governor and the commission are to appoint a director of mental health for a six-year term. The

director, who will be the chief executive officer of the department, must be a physician legally registered in the state of Michigan, with at least ten years' experience as a psychiatrist in the treatment of mental diseases, the administration of mental hospitals, and the conduct of mental-health programs. The commission and the director are to make policies and adopt rules and regulations relative to the operation of the department, the administration of which is to be divided into three divisions—business administration, hospitals, and mental hygiene.

Approximately $100,000 has been appropriated by the legislature for the operation of the department.

The Mental Hygiene Society of Union County, New Jersey

The Mental Hygiene Society of Union County, with headquarters in Plainfield, New Jersey, was incorporated on September 20, 1944, after a meeting of a group that had sponsored and promoted the idea of the society's organization for more than a year. After the preliminary period of educational introduction into the county, the offices formally opened in November, when Dr. Helen Yarnell assumed the position of medical director.

The stimulus for the society's development came from the obvious need for psychiatric services for non-hospitalized veterans, as observed by the coördinator of the Red Cross Grey Ladies at Lyons Veterans Administration Facility, and by a group of professional social workers. While the focus at first was directed to the veterans who needed out-patient psychiatric services, the society later extended its program. The range of services now available constitute a general mental-hygiene program for all persons, both children and adults, in Union County. It has not been necessary as yet to give any preference to veterans' requests for appointments. All cases referred for treatment are accepted on a selective basis.

Dr. Marion E. Kenworthy, Director of the Mental Hygiene Department, The New York School of Social Work, and Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, have given unlimited time for consultation about structure, organization, and standards. Both Dr. Kenworthy and Dr. Stevenson are members of the society's advisory committee.

The professional staff now consists of the psychiatrist, who is the medical director; the psychologist; and four psychiatric social workers, one of whom is the executive director. Another is a research analyst. Research will be dynamic, self-analytical, and related to community needs.

The initial community educational program has been extensive

as well as intensive. There have been talks before lay groups, clubs, societies, and professional organizations. Courses have also been given to selected departments within certain industries.

The society is privately sponsored by substantial, although minimal grants from a foundation interested specifically in the demonstration of a community mental-hygiene program. The society is also a participating member in one of the Community Chests in the county at this time. Funds are to be obtained by memberships to the society and also by campaigns in the various communities. Each community is conducting its own drive for funds through educational and fund-raising committees.

As a traveling unit, the clinic team meets one day a week in Elizabeth, and one day every other week in Summit. On other days and two nights a week, appointments are scheduled for the Plainfield clinic. All appointments are made through the Plainfield office.

Fees are related to the patient's ability to pay for clinic services. The society operates on both a fee and a non-fee basis. Nominally, fees range from fifty cents to five dollars with a median fee of three dollars.

Brochures for the use of physicians, agencies, and other persons interested are still available. Copies of the president's report (March 26, 1945) may be had upon request. A quarterly bulletin will be published in June. Because of printing difficulties this issue may not be ready for mailing until July.

Any inquiries or requests for service should be addressed to the Executive Director, Mental Hygiene Society of Union County, Plainfield, New Jersey.

State Society News

Alabama

The Alabama Society for Mental Hygiene is sponsoring a sterilization bill which is now before the state legislature. The spring meeting of the society was postponed because of travel restrictions, but a ballot by mail reëlected last year's officers: president, Dr. J. E. Bathurst, Birmingham-Southern College; vice president, Mrs. Alvice Sharpe, Children's Aid Society, Birmingham; and secretary-treasurer, Dr. Katherine Vickery, Alabama College, Montevallo, Alabama.

California

The Mental Hygiene Society of Northern California is sponsoring a bill to modernize the procedures for commitment to California state hospitals. The bill, which originally permitted hospitalization on the certification of two physicians, was amended in the assembly to

provide that the admission application shall be approved by a superior-court judge acting *ex parte*.

Misunderstanding of the purposes of the bill and opposition to it have been widespread. However, the society has had the assistance of such groups as the Public Health League, the California Congress of Parents and Teachers, the State C.I.O. Council, and private and public welfare agencies. The bill has passed the assembly and is now before the senate committee on institutions.

Connecticut

The Connecticut Society for Mental Hygiene held its Thirty-seventh Annual Meeting on May 28 at the Chi Psi House in New Haven. The meeting was preceded by a luncheon for members and guests.

Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, was the speaker of the occasion, his subject being "Enlarging the Horizons of Psychiatric Care." Pointing out the need for a more even dispersion of psychiatric care throughout the country, he expressed the hope that the National Neuropsychiatric Act, now in committee in the Senate, would be passed in the near future. This bill, he felt, would go far toward alleviating the situation now facing the nation's doctors and hospitals.

Dr. Stevenson also commended a bill covering the establishment of adequate psychiatric facilities in Connecticut state hospitals, now under deliberation in the state senate, and after discussion of the subject, the society voted to urge the enactment of the bill.

Miss Frances Hartshorn, executive secretary of the society, reporting on its activities during the past year, stressed the need for increasing psychiatric service for veterans and civilians, and the importance of making known to the returning soldier the services available in his community. An increasing interest in mental health, she stated, is shown by the demand for lectures and courses on the subject and for the pamphlets distributed by the society.

At the business meeting of the society the following officers were elected: president, Mr. George R. H. Nicholson, and first vice president, Dr. Paul P. Swett, both of Hartford; second vice president, Mrs. Anthony V. Lynch, Jr., of Greenwich; treasurer, Mr. John R. Daniell, and recording secretary, Mrs. John H. Jackson, both of New Haven.

Iowa

The annual meeting of the Iowa State Society for Mental Hygiene was held in Des Moines in March, reports Dr. Norman D. Render, executive director of the society. In conformance with travel restric-

tions, it was attended only by the executive committee and members in the immediate vicinity of Des Moines. The following officers were elected for the coming year: president, Walter L. Bierring, M.D., of the State Department of Health, Des Moines; vice presidents, Andrew H. Woods, M.D., of Iowa City, and J. E. Evans, Ph.D., of Ames; treasurer, William Miller, M.D., of the Psychopathic Hospital, Iowa City; and secretary, Mrs. M. Opal Fore, of the Clarinda State Hospital, Clarinda.

Through the good offices of Lieutenant Colonel Robert S. Shane, Medical Director of the Iowa Selective Service System, six reciprocal conferences have been held, attended by members of local draft boards and of the Iowa Welfare Association, the Red Cross chairman, and the lay public interested in mental hygiene. At each of these, papers were presented by medical men with illustrations from clinical material.

Dr. Render reports further that the society is circularizing prominent Iowa physicians and citizens, asking their support of House Bill 2550 (the National Neuropsychiatric Act), as recommended by The National Committee for Mental Hygiene.

During the past year the society has sent out 2,750 pamphlets to the general public of the state.

Louisiana

A meeting of the Board of Directors and the Advisory Committee of the Louisiana Society for Mental Health was held on April 4. Among the matters discussed were the appointment of a permanent executive secretary, methods of improving the financial status of the society and of increasing its membership, the addition of a number of actively interested persons to the board of directors, and plans for the establishment of a psychiatric clinic for veterans in need of such service.

Maryland

Word has been received from Dr. Ralph P. Truitt, Executive Secretary of the Mental Hygiene Society of Maryland, that the Maryland Assembly has appropriated $400,000 for the construction of a psychopathic hospital in Baltimore. The hospital will be connected with and an integrated part of the University of Maryland School of Medicine and the University Hospital.

Since 1928 the Mental Hygiene Society of Maryland has maintained the psychiatric out-patient department of the University Hospital and also has had a part in the teaching and training of medical students of the medical school. The building of a psychopathic

hospital in Baltimore has been a principal objective of the society for several years.

Dr. Katherine L. Schultz, until recently senior psychiatrist on the staff of the Psychopathic Hospital in Pittsburgh, has been appointed a member of the society's clinic staff.

Lieutenant Colonel H. Whitman Newell, a member of the society's clinic staff (on leave), was a recent visitor at the society's headquarters. It is his first furlough after three years' army service in the Fiji Islands and in India.

Minnesota

The following report on the activities of the Minnesota Mental Hygiene Society has been received from Mrs. Margaret Clark Lefevre, its executive secretary:

> "In coöperation with national policy, the society did not call its regular annual meeting, but will send out its annual report by mail after it has been submitted to the board of directors.
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> "Two lectures have been held for the general membership since the last report in MENTAL HYGIENE: one, in joint sponsorship with the Dight Institute, on April 16, when Dr. Elmer Roberts, of the University of Illinois, spoke on 'Biological Aspects of Some Social Problems'; and the other at the time of the usual annual meeting, May 4, when Dr. Fritz Redl, of Wayne University, spoke on 'Adolescents in Group Treatment.' The clinical section of the society, composed of social workers and teachers in the Twin Cities, has likewise had two meetings: one in February, when 'Emotional Problems of Delinquent Adolescent Girls' was the subject of the panel discussion; and the other in May, when the discussion was on 'Emotional Problems in the Home Related to the Absence of Men in Military Service.'
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> "Speakers from the society have appeared before such groups as the Home Service Department of the Red Cross in Minneapolis and St. Paul, the Federation of Women's Clubs, the Junior League, the Public Health Nurses, and the C.I.O. forum.
>
> "The society asked the Planning and Research Division of the Council of Social Agencies in Minneapolis for a survey of mental-health facilities in the city with emphasis on recommendations, and this survey is now being completed by Dr. Haven Emerson. As a follow-up, the society has been working toward the establishment of a lay committee of Minneapolis women, and is meeting with other agencies to arrive at a coöperative solution of local problems.
>
> "The board of directors has voted to keep its legislative committee continuously active, pooling resources with similarly interested groups, gathering information, and making early preparations for proposed legislation."

New York

The report of the New York State Committee on Mental Hygiene on the Medical Survey Program for the year 1944 shows that 218,654 registrants of the Selective Service have been "screened" for mental

classification. The report received favorable comment from Colonel Leonard G. Rowntree, Chief Medical Officer of the National Selective Service.

In December, 1940, the committee began a series of experiments to determine whether or not help from civilian health and welfare workers could be used to assist examiners at induction stations in the mental classification of registrants. The experimental work indicated that information about the registrant's background would be a material help in preventing induction of men not suited to military service, because of mental or emotional disturbances.

A program was formulated for securing confidential information about men from the agencies in the communities where they had grown up. The program was accepted by both state and national selective service headquarters.

Welfare workers in 57 counties were organized and service was provided for each of the 260 local boards outside New York City. The New York City Committee on Mental Hygiene provided similar service for boards in New York City. Local boards give to designated social workers and nurses the names of men about to be inducted. Using social-service exchanges, the workers secure information from agencies that know the men. Data that might affect classification are condensed on a short form which is returned to the local board in a sealed envelope. The board sends the material to the induction station in time to be used by physicians and psychiatrists during the examinations. Originally planned to help keep mental misfits out of the armed forces, the program has now been enlarged to include any disability that might make a man unsuitable for military duty.

The Selective Service has supported the program from the beginning. The first directives issued to local boards gave them permission to use the service offered, but it proved to be so useful that the National Selective Service in October, 1943, made it mandatory for local boards to secure information about registrants. At that time assisting welfare workers were sworn in as medical field agents and became officially a part of the Selective Service system. Some 9,000 welfare workers all over the country are now participating.

Miss Katharine Ecob, Executive Secretary of the New York State Committee on Mental Hygiene, has been appointed Social Service Adviser to the New York State Selective Service Headquarters. She states that the most striking feature of the program is the generosity with which welfare agencies and individual social workers and nurses have responded to the request for help. Most of those engaged have full-time positions, but have voluntarily added this duty.

Though many hours of overtime work have at times been necessary for long periods, 600 welfare and health workers are still faithfully "on the job" in New York State.

Oregon

In August, 1944, Mr. Dan Prosser, who had been executive secretary of the Oregon Mental Hygiene Society, entered the navy. There followed a four months' search for a person to carry on the work during his absence. Miss June J. Joslyn was finally selected, and took up her duties January 1, 1945.

After an orientation period, a program was worked out stressing many mental-hygiene needs. Among the chief objectives in the immediate future will be psychiatric services to discharged veterans, community education, and organization of branch societies to strengthen the work throughout the state.

The Baker County Mental Hygiene Society was organized in April, with Rev. S. A. Walker as president. This is really an expansion of the child-guidance committee that has been functioning for several years in connection with the child-guidance-clinic program in Baker conducted by the Oregon Medical School. The Baker Society will plan an active program in the early fall.

Also in April, the Oregon Society was co-sponsor of a seminar on "Counseling on War-Time Problems," conducted by Dr. Charles T. Holman, of Chicago. There were five sessions, reaching over 350 interested people, and the general comment of those attending was, "Give us more."

Facilities for psychiatric treatment in Oregon are at low ebb, the society reports, as many of the state's psychiatrists are with the armed forces. Those who remain, however, are keenly aware of the need for service to veterans. The Oregon Mental Hygiene Society is conducting a psychiatric clinic for veterans on a demonstration basis, and the hope is that more clinical facilities can be provided in the near future.

The annual meeting of the society was held on May 15 in connection with a dinner at the Mallory Hotel. This was a new venture in Portland, and the fact that many who wished to attend could not be accommodated attests to the interest in the field. About 120 members and friends were present. Mr. E. B. MacNaughton, President of the First National Bank, was the guest speaker, taking as his subject "Hard Facts." The executive secretary of the society spoke on "What We Can Do About It," and Dr. Thompson L. Shannon, president of the society, gave his annual report under the heading, "Past, Present, and Future." As a result of the excellent publicity given the meeting, much more work has been coming into

the office, and both Mr. MacNaughton and Miss Joslyn have been asked to talk in several places.

The following officers were elected for the ensuing year: president, Dr. Thompson L. Shannon; first vice president, Dr. D. C. Burkes; second vice president, Dr. Adolph Weinzirl; third vice president, Miss Elnora Thomson; secretary, Miss Nell Unger; treasurer, Mr. Burt Brown Barker.

Washington

The Board of Directors of the Washington Society for Mental Hygiene has appointed as its executive secretary Mr. George F. Ault, who assumed his duties on May 1, 1945. Mr. Ault replaces Miss Marjorie Rice, who was executive secretary until May 1, 1944, and Mrs. Vivian Hodge, who was acting executive secretary until May 1945. The president of the society for 1945–46 is Dr. Ralph M. Stolzheise of Seattle.

The society is extending its program on a statewide basis to include active interest in and support of educational programs, modern institutional facilities, and progressive legislation.

Wisconsin

The articles of incorporation and by-laws of the Wisconsin Society for Mental Hygiene were amended at a special meeting of the membership, May 18, 1945, approximately ten years after the incorporation of the society. The articles were brought into alignment with the present state statutes for non-profit charitable corporations and provide for the structure necessary to insure maximum participation in the program on an area basis.

The name of the society has been changed from Wisconsin Society for Mental Hygiene to Wisconsin Society for Mental Health. It is hoped that the substitution of "health" for "hygiene" will eliminate some confusion with other movements and will also give positive emphasis to the chief objective of the society—the stimulation of interest in healthful living as a means of preventing mental illness and of facilitating recovery from it.

The board of directors will be reduced within three years from sixty to thirty. The larger group, intended by the incorporators to insure statewide interest through representation, has proven unwieldly. The desired interest and concern can be better assured, it is believed, by a policy of continuous preparation of board timber through service on committees and by the election of directors for not more than two consecutive terms of three years each. Active participation is expected of those who consent to serve on the board.

Provisions are made for six standing committees: activities, legis-

lation, finance, publications, membership, and nominations. Wisconsin is largely rural. By area representation and active participation on these committees, and by area "board meetings" and conferences, with the resident directors responsible for the meetings and the guests, the work of the society can be much more successfully prosecuted, it is believed, than in the past.

The duties and responsibilities of the executive director (formerly the executive secretary) are outlined and thus accorded the dignity of formal recognition as a necessary part of the organizational set-up.

Mental-Hygiene Exchange

Wanted—The New York State Committee on Mental Hygiene would like to have a copy of a completed contract between the Veterans Administration and a high-class local mental-hygiene clinic.

Wanted—The National Committee for Mental Hygiene would be very grateful for any copies of the January, 1945, issue of Mental Hygiene that subscribers may not care to keep. Requests for this issue are being received and the edition has been exhausted.

New Publications

The annual report of The National Committee for Mental Hygiene for the year 1944, issued in booklet form in June, bears the title *For Thirty-Five Years,* in reference to the fact that 1944 was the thirty-fifth year of committee's existence. Last year as in 1943, the report shows, the Committee's outstanding contribution was its work in connection with various phases of the war effort. Its regular civilian activities were continued, however, and plans were being made for dealing with the post-war problems that loom ahead. Copies of the booklet, which includes the report of the treasurer, can be obtained by writing to The National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.

An interesting and important contribution to the literature on industry and the returning soldier is a little brochure entitled *You and the Returning Veteran: A Guide for Foremen,* which was prepared by the Allis-Chalmers Manufacturing Company in collaboration with Dr. Esther de Weerdt, Executive Secretary of the Wisconsin Society for Mental Hygiene, and Dr. Ole N. de Weerdt, consulting psychologist. . The outgrowth of a series of talks given by Dr. Esther de Weerdt before the supervisory office of the Allis-Chalmers Company, the little book is apparently meeting a real needs.

"The requests for copies in quantity lots have been amazing," writes Dr. Esther de Weerdt. "Perhaps they constitute, in a sense, a measure

of the hunger for something that is helpful to supervisors of workers when nervousness complicates the picture. We are informed that Allis-Chalmers has exhausted the first two printings, totaling 16,000 copies, and has 5,000 on the press now. Governmental units, large and small private industries, and commercial concerns, as well as educational and professional groups, have asked for copies in quantity.

"Special credit for this project should go to Mr. Lee H. Hill, Executive Vice President in Charge of Industrial Relations, Allis-Chalmers Manufacturing Company, Milwaukee, Wisconsin, and co-author of a recent book entitled, *Management at the Bargaining Table*. He had the necessary vision and courage to undertake the publication. Without the name of a great industry attached, a prominent industrial executive told us the other day, we would not be reaching the particular group that has so large a responsibility for personal supervision of the returning veterans on the job.

"This wide acceptance of the information contained in the *Foremen's Guide* should encourage other attempts to present mental health principles and procedures to average citizens. Only by construing mental illness in terms of the experience shared by all can we break down the fear and prejudice associated with the expert and gain willingness to seek help early. Intelligent, confident coöperation at home and on the job will insure greater benefit to the patient from whatever expert assistance is available."

For further information with regard to the brochure, write to Dr. Esther H. de Weerdt, Executive Secretary of the Wisconsin Society for Mental Hygiene, 405 Grand Avenue, Beloit, Wisconsin.

A detailed directory of the major national voluntary health organizations in the United States, some ninety-six in all, with short accounts of their development and purposes, has been compiled by Harold M. Cavins and published by the Public Affairs Press, of 2153 Florida Avenue, Washington 8, D. C. Fourteen of the organizations, including The National Committee for Mental Hygiene, are discussed at some length, the others more briefly. Dr. Reginald M. Atwater, Executive Secretary of the American Public Health Association, contributes an introduction to the volume. The price is $3.00.

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